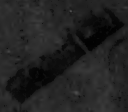

The Public Health Nurse

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BCG IN 1930

Interest in BCG (Bacillus Calmette-Guerin), the famous immunizing vaccine against tuberculosis being used by Dr. Calmette and many others throughout the world, came to a focus at the recent meeting of the International Union Against Tuberculosis at Oslo. For public health workers, BCG holds a deep fascination. Since there is much confusion of thought about this subject, a brief statement regarding the present status of BCG should prove of interest.

BCG, originated by Professor A. Calmette, Associate Director of the Pasteur Institute of Paris, was evolved after years of painstaking effort to produce artificial immunity against tuberculosis by means of the injection through the mouth or otherwise of a living culture of avirulent bovine tubercle bacilli. Many years ago Calmette observed that repeated, mild and small doses of infection in human beings naturally acquired apparently produced a more or less lasting immunity against tuberculosis. Acting on this observation, Calmette proceeded to cultivate a strain of living tubercle bacilli taken from cattle until he reduced their virulence to a point where, he claims, they have practically all of the allergic and immunizing effects of the tubercle bacilli, but they no longer can destroy tissue.

Since July, 1924, and up to June 1, 1930, more than 210,000 children in France have been vaccinated with BCG and in addition thousands of children in other European countries and relatively smaller numbers in the United States. Reports brought together at Oslo by workers from different countries seemed to indicate that BCG is comparatively harmless, but these reports presented relatively little positive proof of its definite immunizing qualities. Unfortunately, the statistics kept by Calmette as well as by some of the others are of such a character that it is difficult to estimate the positive effect of BCG. Experiments are now under way that will assist in that direction.

This fact, however, should be made clear to all public health nurses, that no

one can tell what the results of BCG will be until a sufficient time has elapsed for the present generation of children now being vaccinated to grow up. After this group has grown up and has passed the crucial periods of early and later adolescence and young adult life, the effects of BCG, provided the statistics have been properly kept, can be properly evaluated. In other words it will take from ten to fifteen years to determine with any degree of positive assurance, the real value of BCG. Meanwhile, public health nurses and others are urged to suspend judgment until the laboratory and other experiments now being carried on have been brought to completion.

—*P. P. Jacobs*
National Tuberculosis Association

The New Leadership *

By C.-E. A. Winslow
Professor of Public Health, Yale School of Medicine

THE word, Leadership, conjures up gorgeous visions — of Roland at Roncesvalles, of Luther at Worms, of Napoleon dominating the continent of Europe. It recalls the philosophy of Nietzsche, the dictum of Carlyle that "Universal History, the history of what man has accomplished in this world, is at bottom the History of the Great Men who have worked here." Yet, today, the simple relation of commander and follower, of master and pupil, of lawgiver and subject, seems a somewhat incomplete picture of the complexities of life. The apparently opposing concepts of aristocracy and democracy have been knit together into a new and wider concept of social relationship which might be called Sociocracy. Thanks to John Dewey and to such apostles of group-thinking as Harrison Elliott, Mary Follett, E. C. Lindeman, H. A. Overstreet and Ada Sheffield, we have a vision of a kind of creative thinking, and a kind of common action, in which men function as a group and not a crowd. There is a leadership involved which is no longer mastership. Implicit in this new concept is a belief that the gap between hero and worshipper is less deep and wide than Carlyle and Nietzsche thought — a conviction that the average human being has his own contribution to make to the common task. As Herbert Croly says, "Human beings cannot learn much that is trustworthy about their own conduct or that of the society in which they live unless they come to envisage other human beings as personalities capable of realization and growth." A group, with wise leadership will in the long run arrive at sounder conclusions than the same leader could impose upon the same group. Furthermore, however strong may be the instinct of hero worship, the instinct of self-expression is even stronger; and therefore the conclusion arrived at by a group will be more vitally effective as a motive for conduct and achievement. As Mrs. Sheffield says, "A forward movement in the spiritual life of society may be sought in two ways. We may look to leadership, to great spokesmen of the spirit, who shall draw a people onward by the sheer power of championed ideals to compel assent; or we may look to a creative social process, to a lifting of many voices that take counsel to achieve in the common experience a winnowing of ideals and a reordered life."

* Presented at the Board Members' Institute conducted by the Henry Street Visiting Nurse Service, New York City, November 11–12, 1930.

CENTRIPETAL LEADERSHIP

There is here involved, then, not only a new type of group thinking but a new type of leadership—a leadership which is centripetal and not centrifugal, in which the leader does not radiate force to receptive subordinates, but in which he forms a coördinating center and a channel of expression for a group of vitally functioning sources of independent power. It is a biological rather than a mechanical picture, based on the concept of modern philosophy (and of modern science) that the fundamental reality of this universe of ours lies in relationship and not primarily in the quality or quantity of the individual units which may be concerned.

It seems almost blasphemous to say that you and I with our meager endowments can understand more of leadership than did Luther or Arnold. Many a schoolboy, however, knows more physics than Newton, more bacteriology than Pasteur. I am inclined to believe that the technique of group thinking promises in a similar fashion to give to us ordinary people secrets of leadership which Thomas Arnold could not know.

Group thinking is a new discovery and some of its proponents are human enough to be carried somewhat farther in their enthusiasm than the facts will ultimately warrant. There was a blinding glow of mysticism in Carlyle's worship of his heroes; and there is a similar aura about some modern discussions of the group. There are two fundamental qualifications of group thinking which must be borne in mind.

FUNDAMENTAL QUALIFICATIONS OF GROUP THINKING

First of all, group thinking does not imply a recrudescence of the discredited fallacy that "all men are created free and equal." No man was ever born free and no man was ever the exact equal of any other man. Professor Giddings has said that "all social forces are generated in Grades A and B"—the level of intelligence quotients to which only 14 per cent of the average population belong. Group thinkers bitterly resent this statement; but it is essentially true that most advances in human society have in the past been initiated by exceptional individuals. It will perhaps be in large measure true in the future; yet it is highly probable that there are more leaders in this world, more leaders in nursing boards, for example, than have been dreamed of in our philosophy.

The main fallacy involved lies, however, in the application of a quantitative measuring rod. Discussion as to the relative contribution of leaders and followers is as futile as the classic argument between the belly and the members. If we once accept the biological viewpoint, we shall realize that what is important is the functioning of a group as a whole with each part contributing its share, whether large or small, with a single purpose of furthering the common good. This is our definition of a healthy human body. It should be our definition of a healthy committee or a healthy state. And this is the essence of group thinking.

Something may really be created "when two or three are gathered together"—something new and something superior to the sum of the component parts, just as sodium chlorid has properties quite different from those of sodium and chlorin. Yet, in the last analysis, the product does depend on the ingredients which enter into it. There is no magic involved. The achievements of a group depend on the capacities of its constituent members.

A second important limitation to the possibilities of group thinking lies in the fact that life is, in more and more complex fashions, related to various sorts of technical knowledge. The experts on group thinking are none too cordial toward other varieties of experts; but they all acknowledge that the technical expert must be brought into some direct and fruitful relation with the group. J. B. S. Haldane in the September *Harper's* claims that the real world-revolutionaries have been the changers of the external conditions

of human life, the discoverers and inventors, the unknown pioneers who first used fire and practiced agriculture, and such modern exemplars as Pasteur. It is, of course, largely a matter of definition. Such men as these have certainly been the great changers of human life; but leadership is something different from this. It involves direct contact with human beings—a contact which is fruitful or sterile, beneficent or dangerous, in proportion as it harmonizes with the laws of nature and the techniques of art as the technicians have given them to us. Group thinking may be ever so inspired but will yield no useful results if it has not at its disposal and does not heed the best knowledge of the subject in hand. Democracy sometimes rages against the expert but cannot thereby change the course of natural law any more than a business man can balance an unbalanced budget by smashing the adding machine.

SOLID FACTS FOR CREATIVE THINKING

Leadership of the modern kind must be based on expert technical knowledge and indeed it is perhaps one of the main functions of the group leader to see that creative thinking has solid materials of facts out of which to create. Group thinking must deal largely with values. "What do we want? What satisfaction will it bring us? What sacrifices will it involve, not only measured in dollars but in terms of psychological and sociological imponderables? How much are we prepared to pay?" These are the questions which any group may ask itself. The way in which results can be attained, the nature of those results and their probable money cost—these the expert can tell us. He does not speak with infallibility but he gives us the best current knowledge and the best current technique and he can set down for us its concrete limitations.

The leader is today no less essential to social progress than in the past. As Lindeman says, "Democracy needs, most of all, creative leadership; it must be constantly making proposals which lead the community along the road of idealism." But it is centripetal, not centrifugal force which is needed. As Miss Follett puts it, "The community leader is he who can liberate the greatest amount of energy"—liberate, not radiate, you note. It is said that Mr. E. H. Harriman, after conducting a meeting in which he had insisted on "complete coöperation," was asked what he meant by coöperation. "Do as I say and do it damn quick," he replied. Miss Follett puts it a little differently. She says, "The leader guides the group and is at the same time guided by the group, is always a part of the group."

LEADERSHIP IN RELATION TO STAFF, BOARD AND COMMUNITY

Let us consider now, very briefly, certain characteristics of the new type of leader as manifested in our particular field—the administration of a public health nursing organization—and let us consider them in respect to the three major relationships which a leader in such an organization bears, to her staff, to her board or committee, and to her community.

First of all, let us consider the new leader's attitude toward her staff and toward the expert technical knowledge which that staff represents. She must understand the value and the meaning of techniques and the value and meaning of personalities. She must know that there is—at any moment—a best way to do things and that this "best way" is constantly changing with experiment and advancing knowledge. She will understand the value of training and experience and the need for continuing staff education. She will appreciate that full nursing records are not merely sources of statistics but essential tools of supervision and of policy planning. She will be solicitous to maintain contacts with the stream of fundamental knowledge and of sound current practice for her board as well as for her staff. She will perhaps change the name of her Education Committee to Committee on Research and Criticism.

This brings us naturally to the rela-

tion of our new leader to her own colleagues. She will obviously make it her prime effort to develop and to maintain a board or a committee which is in vital reality a thinking group. The leader of the past knew how to delegate responsibility. That is a basic element of self-protection which the crudest empiricism teaches. You recall the story of an official of the Standard Oil Company in the old days at Cleveland. He was dictating one letter and signing another and listening to the telephone all at once and his desk was piled high with charts and papers when Mr. Rockefeller came in. "Getting off a lot of work today," the executive proudly said. "So I see," replied Mr. Rockefeller, "but I would rather see someone else doing these things and you with your feet on the desk just thinking." The old leader also practiced an elementary kind of mental hygiene, understood his or her board members, knew what would appeal to this one and to that. But all this is elementary. Modern leadership demands something more.

THE IDEAL COMMITTEE MEETING

Perhaps the crux of the new attitude is to be found in the conduct of a meeting. Nothing is much easier to the astute than the manipulation of a meeting. You choose the right time. (I knew a chairman once who always tired his committee with unimportant details for the first two hours and then sprang the trap.) You choose the proper person to make the motion. You have two or three of the right people to support it. You see that ample statistical evidence is at hand. You politely call for further discussion which does not come and the "ayes" have it. You have all probably done this; I know I have many times. But if you will read what the group thinkers have to say, you will not be so ready to do it again.

They suggest to us a very different kind of a committee meeting. They picture a group which is presented, not with a solution but with a problem. A committee in which there is no place for the member who simply votes "aye"; yes-men are the most useless of our social excrescences. Nor is there much more value in the member who is simply present to champion his own preconceived view. The "no-man" is only slightly less valueless than the "yes-man." In the ideal committee there will be a desire on the part of every member to help find the right answer to an open question—an answer that is not "mine" or "yours" but "ours." In such a committee differences are essential for each member if he has anything to contribute, has something which is characteristically his own, but it is given as a contribution to a common cause. He comes not to get or to give but to share in a creative process. There is no conflict between minds. There is a common conflict of all against the common enemy, which is old chaos. But it takes the contribution of all to win this conflict. Heraclitus said, "Nature desires eagerly opposites and out of them it completes its harmony, not out of similars." In such a meeting of minds one finds that greatest of all pleasures to those of supple emotions and athletic intellect, the changing of one's mind, the sudden glorious enlargement of one's vision.

Out of such a meeting comes not compromise but integration, unity of desire not a majority decision. It is time we realized that majority rule is only a very short step along the road of civilization—counting noses is better than breaking heads but only a little better, for behind it all is the ultimate concept of potential force. Group thinking introduces a very different principle. It makes progress of an immediate material kind somewhat slower for its object is to develop thought not to force action. In its essence it represents one of the most significant evidences of spiritual progress which the world has ever seen. The moral ascendancy of the League of Nations is very largely, perhaps chiefly, due to the fact that on external matters action can be taken only by unanimous consent. It is often not possible to act at

all or action may deal only with a very limited area of a great problem; but when action is taken it is of free will. The Geneva technique as a far-reaching demonstration of group thinking is the most important contribution which the League of Nations has made to the progress of civilization.

STOUT AND MIDDLE-AGED MINDS

If you try to practice group thinking in your own boards you will not find it easy. The stout and middle-aged seldom walk or run when they can ride and most of us are very stout and middle-aged in the region of our minds and our emotions. Your boards would probably like to go on in the old way, having the chairman or the staff do their thinking for them. And it would probably be easier for chairman and staff to continue to do so. Yet there is a spark which you can light if you will try, and, once aflame, creative thinking is a joyous process. You will have to be patient and you will have to be wise—with the right kind of wisdom. Someone has said that Plato shared wisdom with the gods, Ulysses with the foxes. If you have Plato's kind you can perhaps make your board really function as a group. You may not take so many actions at each meeting but you will have helped to create that noblest of all created things, an organism. You will be building not merely an organization but a living thing.

A COMMUNITY PHILOSOPHY

Finally, the leader of a visiting nursing organization has relationships which go far beyond her own group. She and her colleagues make the essential contact between their organization—a public service organization—and the community which it serves. There is room—there is urgent demand—for a larger synthesis, for the application of group thinking between the groups themselves which make up the community as a whole. Lindeman reminds us that institutions "become social dangers when they proceed without a science or a philosophy." The directors of nursing agencies must have a science and a philosophy and they cannot work it out safely for themselves and by themselves. The health agencies of every community should be knit together into a health council so that they may jointly think out their problems and jointly plan, in conference with the health officer who is ultimately responsible for the whole health program of the community, what their own part in that health program should be.

Finally, the health program itself must be integrated with the wider social program of which it forms a part. Here, as in the smaller field within the organization, it should be not a question of votes and victories, not a display of force or of the wisdom of foxes, but a creative group planning for the common good. Royce's principle that the test of our philosophy is the largeness of its loyalties is still sound today.

In such a common service as this the voluntary nursing agency may be contributing more than we realize to the cause of social progress—far beyond its direct contribution to the public health. Old forms of social organization are under fire and old types of leadership are falling into disrepute. As Lindeman says, "There are true leaders, false leaders, assumed leaders, presumed leaders, self-imposed leaders, accidental leaders, leaders out-of-their-sphere, selfish leaders, social-prestige leaders, economic-prestige leaders, political-prestige leaders and leaders undiscovered." True leaders are functioning in the direction of our voluntary social agencies, undiscovered as leaders even by themselves.

Miss Follett thinks that "'Representative government,' party organization, majority rule, with all their excrescences, are dead wood. In their stead must appear the organization of non-partisan groups for the begetting, the bringing into being, of common ideas, a common purpose and a collective will." I am not quite sure what this means; but it has often seemed to me that the growth of our voluntary

social agencies did indeed perhaps represent the shadowy beginning of a new form of social organization which may be no temporary phenomenon but a presage of changes which will make the Nineteenth Century conception of the state seem as archaic as that which was envisaged in Machiavelli's Prince. It may well be that such organizations as are represented at this Institute are not only leaders in the care and prevention of disease but perhaps all unknowing, also leaders in our progress toward that day when the state shall be neither the master, nor the servant of the people but the people—"the keynote of the social arch and the arch in its wholeness."

EARLY DIAGNOSIS CAMPAIGN

Monument to Theophile Laennec, inventor of the stethescope, at Quimper, France. From a photograph sent to us by Ada M. Carr.

Under a new plan of attack on disease, the 1,400 tuberculosis associations of the United States are to begin April 1 an intensive effort to fight tuberculosis in the sector of youth. For despite the general reduction of the death rate from this disease in the last twenty years, it still kills more persons between 18 and 35 than any other cause, and has the high death rate of 120 per 100,000 in the age group of 20 to 24, while among the population as a whole, the rate is only 76.

Boys and girls have been discovered in active high school work, leaders in athletics and scholarship, apparently in good health, but actually with tuberculosis smoldering within them, soon to break into flame. Modern scientific progress has brought with it the tuberculin test and the X-ray—aids to physicians to discover cases in time to check the disease—even before any symptoms are noticeable.

The teen ages and early twenties particularly constitute a period of very great stress and strain. It is a period of adjustment from a relatively easy life to the earning of a livelihood, the building of a home, and the rearing of a family. Perhaps dissipation is practiced more excessively at this age period than at any other in life's span. From our present knowledge, it would appear that this adjustment period plays an important rôle in the development of the adult type of tuberculosis. We must not overlook the primary infection which may have appeared from a few months to many years before. We must not overlook continued sources of exposure. We must detect at the first opportunity the boys and girls who have been excessively infected. They should be placed under close observation, should be taught that they are potential cases of the adult type of tuberculosis and, therefore, must observe strict rules of living and avoid those activities which operate to deplete the already strained resistance of the body.

No one is in a more strategic position to advise medical attention at the slightest sign of stress or strain in adolescence than the public health nurse. Her interest in this campaign is solicited.

Has your organization received a Census Form? Census Forms were sent out February 2.

Has your organization returned a Census Form? Returns should be in the N.O.P.H.N. office before May 1.

Infantile Paralysis *

(Epidemic Poliomyelitis)

By Ludvig Hektoen, M.D.
John McCormick Institute for Infectious Diseases, Chicago

A HUNDRED years ago, the knowledge that there was such a disease as the one we call "infantile paralysis" was just beginning to be established. Fifty years ago, it was known that infantile paralysis was a communicable disease, that it may be transferred from one person to another. Twenty-five years ago the experimental study of infantile paralysis began and from that study we have learned what we know about the nature and cause of the disease.

When I was a medical student (and that lies between fifty and twenty-five years ago), I do not recollect that a single word was told us about infantile paralysis in such a way that it made an impression on us.

Epidemic and Seasonal Occurrence

In 1894, the disease was recognized as epidemic in Vermont, but the great epidemic in this country occurred in 1916 in New York State and adjacent districts. It is generally stated that there were 27,000 cases throughout the United States in 1916.

That focused attention on the disease as a public health problem, not only in the prevention of its spread but also in the aftercare of the paralyzed patients. Ever since then we have had here in Chicago, more or less severe, always distinctly recognizable outbreaks of the disease during the summer seasons. The summer, or rather the late summer and early fall, is the season for infantile paralysis, in this part of the country anyway. We do not know why this is so. By the time the first frost appears, infantile paralysis will probably cease to be of immediate concern as an acute disease in this community. During March and April there may be smaller outbreaks of the disease.

Why Infantile Paralysis and Epidemic Poliomyelitis?

We have two names for this disease—infantile paralysis, and epidemic poliomyelitis. Why two names? It is called "infantile paralysis" because it is characterized in severe cases by paralysis and it occurs mostly in young children. It is ordinarily stated that 70 per cent of the cases occur in children below five or six years of age, so that "infantile paralysis" describes that aspect of the disease very well.

Epidemic poliomyelitis is the other name. "Poliomyelitis" means an inflammation of the gray matter of the spinal cord, and the disease usually occurs, as I have indicated, in epidemic form; consequently, "epidemic poliomyelitis" is a very good term from the point of view of the epidemic nature of the disease and the location of its main lesion, namely, in the anterior horns of the gray matter in the spinal cord.

The nerve cells in the anterior horns of the gray matter of the spinal cord are the centers for the nutrition and function of the voluntary muscles—the skeletal muscles. The virus of infantile paralysis attacks the cells in the anterior horns of the gray matter in the spinal cord; it localizes in these cells, causes more or less inflammation of the surrounding tissue and may even destroy the cells This gives rise to paralysis and atrophy of the skeletal muscles, particularly the muscles of the arms and legs.

Cause

The cause of infantile paralysis is believed to be an invisible virus. By

* Report of talk to the staff of the Visiting Nurse Association of Chicago. A "Mr. and Mrs. Edward Gould Shumway Memorial Lecture" for 1930.

that we mean a living organism which is so small that it cannot be seen under the highest powers of the microscope and that it passes through filters that retain all ordinary microbes like the diphtheria bacillus, the staphylococcus, etc.

Monkeys are the only animals that react to the virus in practically the same way that man does. Experiments with monkeys have thrown much light on the nature of infantile paralysis. All the various forms of infantile paralysis can be reproduced in the monkey by injecting, under suitable conditions, extracts of the spinal cord of patients who have died of infantile paralysis. It is from such work that we have learned what we do know with certainty about the nature and cause of the disease. It is another example of how absolutely essential to the progress of knowledge in regard to disease, animal experiments are and ever will be, so far as we can tell at the present time.

SUSCEPTIBILITY

One interesting feature about infantile paralysis is that the susceptibility to the disease is, after all, limited. If we take 100 children who so far as known have never had measles and expose them to measles, between 90 and 99 of those children will get measles. If we do the same thing in the case of scarlet fever, perhaps 50 or 45 of the 100 would contract scarlet fever. If you were to do that in the case of infantile paralysis, perhaps only one or two of the 100 would get the disease in recognizable form. I want to illustrate what I have just said by asking all of you who have had measles to raise your hands. (It looks to me as if practically every one of you has had measles.) All of you who have had scarlet fever raise your hands. All who have had diphtheria. (You see there are very few.) That illustrates, in a rough way, how the natural susceptibility of human beings to certain infectious diseases appears to vary.

In the case of infantile paralysis, we have good reason to believe that the infection in mild form occurs more extensively than we realize, without any paralysis, and that in fact only a small minority of those infected develop paralysis.

We know from observation both of human beings and of monkeys, that one attack of infantile paralysis produces immunity against future attacks. Physicians believe that this small susceptibility to the disease that I have just emphasized may be due, in no small degree, to previous immunizing attacks that fortunately passed by without any paralysis.

SPREAD

So far as we know the disease is spread by contact with patients in the early stages or with healthy carriers of the virus of the disease. In other words, it is communicated from one human being to another. The more frequent source, I suppose, is the patient, either with a mild form or the more severe form, and the carrier, who does not react to the virus in any recognizable form.

The means of spread are the secretions of the mouth and nose. Sometimes we hear that the disease may be communicated by animals, by insects and in other ways but there is no proof that such actually is the case.

On the other hand, that the disease does travel by contact of one person with another can be seen in the spread of the disease in certain country districts or small towns where the conditions are simple, much more simple than they are in a huge city or a metropolitan area like Chicago and the surrounding district.

Why do we have an epidemic in New York with some 12,000 obvious cases while here in Chicago at this time we have an epidemic of perhaps 75 cases to date this season? The answer can be suggestive only. There might have accumulated in New York several crops of susceptibles; whereas in Chicago, at the present time, at any rate, we are having infantile paralysis summer after summer, season after season,

and consequently the new crops of susceptibles that are coming along are relatively small, mostly young children. Perhaps thousands of others have unrecognized attacks of the disease. At any rate, it is by thinking along such lines that we can form any satisfactory explanation of the way the disease manifests itself.

SYMPTOMS

The symptoms we may divide into the early non-paralytic or preparalytic symptoms, the paralytic symptoms, and the later symptoms. The disease may begin in a very mild way and then, like thunder out of the clear sky, paralysis develops and the nature of the condition is at once clear. Or there may be no paralysis at all and we may not ever be sure just what was the nature of that particular attack.

In the more severe forms, the disease begins as a fever, with perhaps sore throat, discharge from the nose, listlessness, nervousness, twitching of the muscles, pain in the head, and in the back. Pain on manipulating the head and back is a particularly significant symptom. There may even be convulsions.

These symptoms are not distinctive of anything in particular; and they are not all present in every patient. Several diseases begin in that way, more or less. But when you have general symptoms of that character, especially pain in the neck and spine, and when nervousness seems to predominate then we should at once think of the possibility of the beginning of infantile paralysis.

But those symptoms alone would hardly be sufficient, even if they were marked, to establish a diagnosis of infantile paralysis in a given case. By examination of the spinal fluid, however, in the presence of such symptoms, the diagnosis of infantile paralysis can be made definitely in the preparalytic stage, that is, before any paralysis has developed, or when paralysis fails to develop.

The spinal fluid in such a case is under tension. There is more of it than there should be. It contains more cells, particularly more cells with a single nucleus, and more protein than normally; so that it is perfectly possible for a skilled physician to make a diagnosis of infantile paralysis without paralysis being present.

That is very important, because if such a patient is treated in the proper way during this stage, we have reason to believe confidently that paralysis may be prevented. Mothers, nurses, physicians should realize this situation, so that the attention will be focused early on the child that is coming down with some sort of illness in the way that I have outlined, especially during the season for infantile paralysis.

The next stage is the development of definite muscular paralysis. That may come on in two days, in six days or as late as eight or nine days after the appearance of the general symptoms that I sketched so casually. Then there is no longer any question about it and I shall not attempt to describe the paralysis as it appears in the various muscles that may be involved.

Almost at once after paralysis there begins a progressive atrophy of the paralyzed muscles because they are cut off from the nutritional centers in the anterior horns of the gray matter of the spinal cord. If you don't know where and what those horns are, you can not fully understand the nature of infantile paralysis at all.

PREVENTION

How will you prevent infantile paralysis? There is no serum, there is no vaccine or anything of that sort that can be used generally to prevent infantile paralysis. We can do something to prevent the disease if, during the season of infantile paralysis, we confine the range of movement of young children just as much as possible. If we can keep them from going traveling, from coming into contact with older people who may have come in contact with infantile paralysis or carriers of the germs of infantile paralysis, something may be done to prevent the disease.

If infantile paralysis breaks out in a family, then, of course, isolating the patient carefully must be carried out to prevent the infection of other members of that family. It is a fact that multiple cases in the same family are unusual. Sometimes they do occur, however.

The secretions from the mouth and nose, even when people are careful, may contaminate the surroundings of a sickbed. On this account, dishes, utensils, linen and any objects that come in close contact with patients, should be cleansed thoroughly. Milk should be boiled; the eating utensils should be washed in hot soapsuds, etc. That is about all we can do to prevent infantile paralysis, speaking generally.

TREATMENT

The treatment of early cases differs from that of later cases.

By early cases we refer to the stage before the paralysis has set in or very soon after paralysis has become apparrent, while there is still fever, while the patient is still acutely ill. In addition to careful nursing and good general care, the main thing to be done is to give such patients what we call convalescent serum or blood, which contains substances that neutralize the virus of infantile paralysis.

Convalescent Serum — Convalescent serum is serum from the blood of a person who has recovered from an attack of infantile paralysis. It is generally assumed that the sooner after a recovery the serum can be obtained, the more effective it will be. But from experiments on monkeys and observations on human beings, we know that the serum of persons who have had infantile paralysis remains potent for many years. The serum does not need to be used immediately after the blood is taken. It can be kept in the laboratory under proper conditions for months and even a year or two without losing its effect. Of course it requires expert technique to secure the serum and to give it to the patient. That is the function of the physician.

The serum is supposed to have good effect only during the earliest stages of the disease. It may have some effect even after paralysis begins but when paralysis is well established and the fever is past and the patient is apparently recovered from the acute attack, the serum cannot be expected to have any effect.

The serum is given by spinal and intravenous injections. The intravenous dose is 100, 150 or 200 c.c. spread over a period of one or two days, while the intraspinal dose is 10 to 15 c.c.

Recent observations indicate that the blood of so-called normal persons may carry neutralizing substances for the virus of infantile paralysis. Probably such blood will be used to some extent in the treatment of patients. For instance, children will be treated promptly with the blood of one or both parents. This is as yet in the experimental stage.

It is only within the last few months that we have been sure that the blood of normal human beings may have any power. The value of apparently normal blood may be another indication that mild attacks of infantile paralysis without paralysis are more common than we know; in other words, the virtue of normal blood or serum may be the result of the immunizing effect of an unrecognized attack of the disease.

In using convalescent serum or normal blood, the donors must be free from syphilis. But in cases in which it is proposed to treat the child with the blood of parents, it may seem safe to omit the tests for syphilis though not always with entire safety.

Inasmuch as many cases of infantile paralysis do recover spontaneously, without any treatment by serum, it becomes difficult to judge, truthfully, what the effect of the serum is, if the patient recovers. But convalescent serum has apparently had brilliant effects in well studied cases in the acute stage. There is nothing else to do but use it in suitable cases wherever we possibly can.

If you are asked to secure donors of convalescent serum, tell each patient (or parent) that the amount of blood

taken will not be enough to hurt the donor in any way. Blood may safely be taken more than once from the same adult donor if a suitable interval elapses between the bleedings. The physician securing the blood for serum estimates carefully the amount that can be taken without causing discomfort to the donor.

A SELF-LIMITED DISEASE NEEDING AFTERCARE

Infantile paralysis, just like measles, like scarlet fever, like typhoid fever, is what we call a self-limited disease—that is to say, the infection takes place, the patient reacts in a certain way and then, if he does not die, recovery follows. The disease limits itself, we may say that it cures itself. But unfortunately, when there is paralysis, there is a great deal to do that nature, if left to herself, does not seem to do so very well.

I refer to the aftercare, the treatment of the paralysis, to the prevention of deformities, to doing what can be done to restore function. And here is where the public health nurse comes in, as a most important factor in the situation. It is essential that there be the closest coöperation possible between the patient, the parents and friends of the patient, the physician and the nurse. Upon the nurse, I think, falls the major task of maintaining that coöperation over the long period of aftercare.

I shall not go into any details in regard to muscle training, massage and such things, because that is entirely out of my field. Read the little booklet published by the Visiting Nurse Association of Chicago,* and Miss Johnson's article on the nursing care of infantile paralysis. Both tell you a great deal about the various phases of the care of the patients.

* Jessie L. Stevenson, Supervisor Orthopedic Division, Chicago Visiting Nurse Association, is preparing an article for this magazine on the aftercare of infantile paralysis cases.

DISCUSSION

Editorial Note: Dr. Hektoen's address called forth several questions from the staff nurses, which we have the privilege of publishing with his answers.

How does serum prevent paralysis?

It neutralizes the virus that attacks the cells in the anterior horns of the gray matter of the spinal cord. In order to do that best, it must reach those cells and so serum is injected into the spinal canal, 10 or 15 c.c., depending somewhat upon the age of the patient, and also intravenously in larger quantities—150 to 200 c.c. spread over a period of one or two days. An effort is made to saturate the patient with the serum. You see what a huge quantity is required and how difficult it is to supply the serum if there are a great many cases to treat.

Has this been proved?

It has been proved experimentally on monkeys and it is practically an established claim. That is to say, the conservative physician of good judgment who has seen the effects of serum, believes that the serum does neutralize the virus of the disease.

Neurologists sometimes say "encephalitis" when other physicians give the diagnosis of poliomyelitis. Have the two diseases so much in common?

Yes. They have a good deal in common in the way of symptoms, especially when poliomyelitis extends higher into the nervous system, and goes into the lower part of the brain. Then it may be difficult to distinguish between the two. But typical encephalitis is not associated with muscular paralysis of the limbs.

How often may blood be taken from the same patient? Should there be a definite period of rest between the taking of blood or is it safe to take as much as the patient seems able to give—that is, several times within a few days, for instance?

There should be a week or so of rest after each bleeding but when the person is an adult in perfectly good health, there is no reason why he should not give up a pint or so several times.

How long does the acute stage usually last?

If we have reference to the fever as the measurement of the acute stage, then it would mean from six to ten days. If we take the acute stage to mean so long as the patient has

pain in the muscles and lameness on movement and is still obviously under the influence of the infection, even though the fever has subsided, then we must extend the acute stage to three or four weeks or even longer.

How soon following the acute stage may exercises and massage be given?

That is a difficult question. The only answer I can give is not before the pain in the involved limbs has disappeared completely.

Many patients give a history of an injury preceding the illness—for example, a fall. May injury be a predisposing factor or does the injury come as a result of the weakened muscles?

Certainly the latter happens in patients under observation. Whether injury may be a predisposing factor or not, I cannot say, with certainty. It is a little difficult to see how it could be and yet an injury upsets the whole body. If you have been in an auto accident, even if only your glasses are smashed, you know how you are shaken.

The Work of a Rosenwald Nurse

By Emily W. Bennett

Director of Midwife Instruction, State Health Department, Richmond, Virginia

SOME years ago, Julius Rosenwald of Chicago became interested in negro education, especially in aiding negroes in the South to build better school-houses. In Virginia alone there are now 336 Rosenwald Schools. His interest has extended to raising the standard of negro health. What he has done for negro education, he is now offering to do for negro health.

In September, 1928, a letter came to the Virginia Health Commissioner from a representative of the Rosenwald Fund, offering to pay one-fourth of the salary and expenses of negro public health nurses working under the supervision of the State Health Department. The Department began right away to try to take advantage of this offer.

The annual salary and expenses of a trained public health nurse amount to $2,100; if one-fourth was paid by the Rosenwald Fund, a balance of $1,550 was left to be raised mainly by voluntary contributions. It seemed impossible for any one county to undertake such a task, so the following group of counties where the negro population is very large was selected: Brunswick, Greensville, Isle of Wight, Mecklenburg, Norfolk, Nottoway, Princess Anne and Southampton. Various white women's organizations in these counties helped with funds, the State agreed to pay $300, and through the efforts of the President of the Virginia State College for Negroes, the balance was secured. In each county the President appointed a chairman, usually the supervisor of schools, to collect its quota of $100, while he himself agreed to collect from varying sources the sum of $200.

It was quite remarkable how these women worked and how willing the people themselves were to contribute. In Southampton County, gifts from 25 cents to $5 were sent in, and in two weeks the chairman for the county had the sum of $100. In Mecklenburg County a banquet was given and from the proceeds a check for $100 came to the Health Department.

The first Rosenwald Nurse to be employed was Nurse Rosa Taylor, who went on duty in Princess Anne County, September 1, 1929, and has charge of the eight counties. She spends two weeks in each county until she has completed the rounds, and then begins again with the first one. In this group of counties the maternal and infant death rate is very high; 23 colored mothers lost their lives in one year as compared to 3 white ones, and there were 254 colored infant deaths to 84 white ones. For this reason it seemed advisable for the nurse to confine herself to a specific piece of work—super-

vising midwives, holding classes for mothers and working with mothers and babies.

HEALTH CLUBS

The territory to be covered in the group of counties is so large that it seems impossible to do very much individual work at present. So, in order to come in contact with as many people as possible, Health Clubs are formed in connection with the School Leagues. Instead of holding a separate course for midwives, they are asked to attend these meetings.

At the first meeting of the health club, a health talk is given and everyone is asked to enroll for the correspondence course for mothers, given by the State Department of Health. A leader is appointed who will meet with the club once a week and give the lessons when Nurse Taylor is away. When she returns at the end of three months, the correspondence course will have been completed, and the club members are ready for instructions and demonstrations by the nurse in bed making, bed baths, bathing a baby, postnatal care, etc. The club will then meet once a month and take up some definite piece of health work. In some instances they have decided to make all homes in their community Four Point Homes. Another club will see that all babies under two years of age are immunized against diphtheria. For the benefit of women who are unable to have a doctor during confinement, each club will see that there is at least one good capable woman in the community who has had some training as a midwife.

The following statistics will give an idea of what has been accomplished from September 1, 1929, to September 30, 1930:

Midwife Classes, 31; attendance	239
Home visits to midwives	375
Mothers Classes organized, 98; attendance	1,406
Health talks to groups, 133; attendance	5,000
Home visits	993
Number enrolled for Correspondence Course for Mothers	2,600
Prenatal cases	251
Postnatal cases	65
New babies	50
Under supervision	66
Visits to infants under two years of age	259
Visits to doctors	75
Visits to registrars	38
Visits to ministers	29
Visits to influential people	129

These figures, as well as reports from Health Officers, County Nurses and individuals make us feel that this first year's demonstration has been well worth while. It is hard to give an idea of the interest, enthusiasm and earnest desire for health instruction shown by the club members, but their determination to put into practice what they have learned makes us feel that a very far-reaching piece of health work has been started. One Health Officer remarked that a foundation for health work among the colored people in his county has been laid by the Rosenwald Nurse which will last for generations.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR MARCH

Pellagra	Vernon E. Powell, M.D.
Nursing Care of Pellagra	Lillian Cumbee, R.N.
Vitamins	E. M. Geraghty
Protection for the Older Nurse	Carrie M. Hall, R.N.
School Nursing—*A vocational article*	Ann Dickie Boyd, R.N.
The Nursing Care of Goiter Patients	W. H. Sprunt, Jr., M.D.
Perineal Care.	
Nurses of Leisure	Ruth B. Scott, R.N.
One Hundred Robb Scholars	Katharine DeWitt, R.N.
What's Worth While in Nursing	Richard C. Cabot, M.D.
Scarlet Fever Immunization in Student Nurses	Charlotte Johnson, R.N.
Is it Worth While to Make Up High School?	Helen W. Munson, R.N., and Nellie G. Brown, R.N.
Some Specialists—Grace Heidel, R.N.	Margaret Kearney, R.N.

How We Found the Cost of Our Hourly Appointment Service

By Mary E. Edgecomb
Director, Public Health Nursing, Out-Patient Department,
Englewood Hospital, Englewood, N. J.

THE Englewood Hospital through its Public Health Nursing–Out-Patient Department offers a generalized nursing service to the communities within the hospital district.* From the beginning (1924) this service has been used freely by all economic groups and, almost from that time, there have been requests for nursing at times most convenient to the patient, in other words, by appointment. These calls gradually increased, but because of a fairly large territory it did not seem as if the regular work could be covered if we committed ourselves to the establishment of an appointment service. In 1929, however, it was evident that we could no longer disregard what seemed to be a definite demand and a very apparent need in the community. It was, therefore, decided to add an extra nurse at the beginning of the fiscal year, November 1, 1929, and give an hourly appointment service a fair trial, but it was also agreed that it must not in any way curtail the regular program of service for all, irrespective of the basis of payment.

The extra nurse has been absorbed into the general service and the appointments are taken by the nurses working in the district from which the call comes, as nearly as possible the same nurse carrying a case through. The service is only offered during working hours, 8:30 A.M. to 5:00 P.M., because so far there has been no demonstrated need for an evening service.

Because of inadequate trolley and bus service, automobile transportation is used almost entirely. At present, there are five automobiles in the field.

During the year ending November 1, 1930, the entire staff made a total of 23,589 home visits to 3,543 different patients and every one of the twenty-three towns and boroughs in the hospital district were visited. Six hundred of the 23,589 visits were on an hourly appointment basis to 176 different patients. These patients lived in thirteen communities, representing a fair cross section, from one end of the territory to the other, north and south, east and west. Forty-six different physicians used the service. These figures indicate a fairly general need for and use of the service. The only publicity was a letter sent to each physician in the community, announcing the service.

Working out the initial charge

It was obvious that the service must not only pay for itself, but there must be a margin of safety to cover unforeseen expense connected with it and to tide over the months when the salaries of extra nurses needed for busy months must still be paid. There is also an additional factor which must be recognized although it cannot be reduced to time or money. While no perceptible time is lost, there may be a slowing up of the work because the day cannot be used quite as advantageously when it has to be planned around definite appointments.

Our regular fee for a full pay visit is $1.10, the actual cost of the visit; we also have a "special fee" of $2.00 for such treatments as colonic irrigations, bladder irrigations, etc. The public was therefore ready to accept a fee of $3.00 for the first hour and at the rate of $2.00 for each succeeding hour for the new hourly appointment service, and there has been no criticism

* See full description of this service in The Public Health Nurse, March, 1930.

of this fee either from the patients or physicians.

While it was felt that the new appointment service would absorb almost entirely the "special fee" patient, this has not proved to be the case, because, in addition to the hourly appointment visits for the year, there was a total of 1,003 "special fee" visits as against 985 of the preceding year.

COMPUTING THE ACTUAL COST

Time consumed rendering the service was used as a basis of computing the cost to the Department. This cost seemed to divide itself into nursing time, transportation, travel time and office time, all of which could be easily computed if we could ascertain the cost *per minute* of nurses' time and of transportation time. These figures were arrived at in this manner:

The total cost of the entire services of the nurses was divided by the total hours (reduced to minutes) worked by all the nurses. This gave a cost per minute of nurses' time. The average cost for the year was $.0145.

The transportation cost per minute was obtained in like manner by dividing the total automobile cost by the total number of minutes of travel for all service. For it the average cost for the year was $.0068.

These figures gave us the two units necessary to compute the actual cost of the appointment service and was arrived at in this way:

Nursing Cost—The total minutes in the home on hourly appointment calls multiplied by the cost per minute gave us the cost of the actual nursing care:

38,937 minutes × $.0145 = $564.70.

This is the time paid for by the patient, but the actual cost of the visit must include both transportation and office time:

Transportation Cost—The time charged to each visit was one-half the time required to get to the hourly appointment patient and from that patient to the next call, and transportation cost included automobile cost plus the cost of the nurse running the automobile. The transportation cost was therefore:

Nurses' travel time—

7,643 minutes × $.0145 = $111.37.

Automobile—

7,643 minutes × $.0068 = $52.51.

Office Cost—The total time spent in office by the entire staff doing routine office work, keeping records, reporting to doctors, in staff conference and supervision, divided by the total visits (all services) gave us the minutes per visit for office work, and this figure multiplied by the cost per minute of nurses' time gave us a cost per visit of $.2320.

Office cost per visit $.2320 × 600 visits = $139.23.

The total cost of the hourly appointment service was, therefore, $867.81. There were 600 visits made on an appointment basis which makes the cost per visit of this service:

$867.81 divided by 600—$1.446 or $1.45 per visit as against $1.10 of the regular public health nursing service.

With a total of 7,643 minutes spent in travel, 38,937 minutes giving nursing care in the homes, plus the prorated office time, there have been approximately four and one-half months of one nurse's time spent in this service.

INCOME

The earned income from the hourly appointment service for the year was $1,960.00, of which $1,684.00 has been collected and $276.00 was still due November 1.

In conclusion, it would seem as if this analysis of our hourly appointment service demonstrates that for the past year the work has not only paid for itself, but that there has been a "margin of safety" and it would seem that we are not only justified in continuing the service, but should have confidence to extend the work in any way possible to meet the needs of the community for a part time nursing service by appointment.

The Mental Hygiene Clinic — A Public Health Nurse's Resource *

By E. S. Rademacher, M.D.
Clinical Director, Connecticut Society for Mental Hygiene

THE preservation of public health is carried on through a great many agencies and institutions, and not the least among such agencies is the younger member, the Mental Hygiene Clinic. There has been perhaps no social movement which has had such rapid growth and widespread acceptance as has mental hygiene. In all social work there is seen evidence of a psychiatric thread. In group work, courts and prisons, in education from the nursery school through the colleges, even in industry, mental hygiene has been included as an integral part to facilitate the best understanding of the individual. It has gone far beyond the point where we can speak of it as a passing fad. Rather, it has demonstrated itself as a growing social need. It would seem, then, a knowledge of the mental hygiene facilities in the country and state, and particularly in the community, should be a very definite part of the public health nurse's equipment.

A second point follows in very quick and natural sequence, namely: What particular problem falls to the province of the mental hygiene clinic. The statements, conservation of mental health—prevention of nervous and mental disorder—after all, carry only vague impressions. The terms "psychiatrist" and "psychiatric" so closely associated in mental hygiene work also convey vague impressions of asylums, state hospitals, mysticism and supernaturalism, and at once need clarifying. Psychiatry in its development no longer limits itself solely to the traditional asylum diseases. Rather it has become the medical study and treatment of every aspect of human endeavor, ranging from the simplest defects and difficulties of adaptation to the more serious difficulties which may require institutional care. Mental hygiene has been a natural outgrowth of the study of the mental diseases, for it has been illustrated time and again in working with these patients that their problems arose earlier in their lives and often from relatively simple difficulties in their adaptation. It is apparent that preventive work in this field must be carried on before the individual's conflicts with himself and his environment reach that point when he can no longer contain himself within society. The part of the mental hygiene clinic, then, in the scheme of public health is that having to do with unusual behavior, attitudes, and personality traits of the individual which may bring him to odds with society or which prevent him from working to his utmost capacity and from gaining the maximum of happiness. This is the first phase of the work of mental hygiene, to bring about the adjusted, well integrated and happy adult, one who is fit to withstand the demands which ordinary life places on him. The second phase is educational, to prevent those situations in homes, in schools, in institutions and other groups, which often are the forerunners of the unadjusted person.

NOT THE MILLENIUM

Now I would bring in a word of caution. The mental hygiene or child guidance clinic does not mark the millenium. It is not a panacea for all evils, and psychiatry does not work miracles. One is surprised even after two decades of mental hygiene progress

* Read May 15, 1930, at the Annual Meeting of the Connecticut State Nurses Association, Meriden.

to note the conditions and situations which the clinic is expected to change overnight. Subjecting the individual to psychiatric scrutiny does not mean as one fond parent expected, a sudden burst into song on the part of a child who hadn't talked for years; nor as one school principal demanded, attentiveness in a history class so dull and uninteresting that it was attractive to the feeble-minded only; nor as one social worker desired, righteousness and dependability in a chronic alcoholic who beat his wife. The mental hygiene clinic does, however, hope to find the cause back of the undesirable behavior or the unfortunate attitude and effect its treatment plan on the basis of the causative mechanisms.

HOW THE WHEELS TURN

This leads us to the third point in our subject, namely: How does the mental hygiene clinic function? Biologists tell us we are all a product of our past. We are a composite of the heritage of generations. Here then is where the mental hygienist must start in his search for causes. Social investigation plays the first part in the clinic study. But the social investigation must do more than merely chronicle the patient's heritage. Science also teaches that we are not only a product of our past, but also a product of our past modified and moulded by the environmental stresses and strains brought to bear on us. The complete social history aims to cover both of these phases of the individual so that as complete a picture of the social influences of his life as is possible to obtain, is brought to light.

Then follows the thorough physical and laboratory study—and this is an important investigation. While factors in physical health have a tremendous influence on the individual's behavior and personality, there is need of further emphasis on the fact that the physical signs and symptoms cannot be treated as isolated bits of pathology but must always be considered from the standpoint of the dynamic effect which these findings have on the whole individual. We appreciate this vaguely when we consider the crippled child, bedridden as a result of his affliction. We readily appreciate that his must be an unhappy lot, but we fail to realize that the more subtle physical conditions will likewise have influence on the individual's life and his attitude to the world.

Next comes the psychological examination, obviously an integral part of the clinic procedure. One must know something of the individual's innate capacity to react to life before any plan of readjustment can be mapped out. This brings up a consideration of the feeble-minded. Retardation of mental development is a condition now more widely recognized with a resulting tendency immediately to refer all such cases to the clinic. Feeble-mindedness is not curable and is not particularly a clinic problem, but rather an educational one. It is true the feeble-minded have emotional conflicts, but a great many of these are directly traceable to an improper school placement where the child is far beyond his depth and has no opportunity for any satisfaction along lines of educational achievement. These cases should be referred to other sources first before consideration by the clinic is asked.

And lastly, we must have the psychiatric examination to probe the emotional realms; to ascertain the individual's attitudes and ideas in relation to his past and his present environment; the satisfactions and frustrations which he meets in his everyday living. All of these findings are then considered in relation to him and he in relation to the rest of the world. This constitutes the clinic study of the person.

These three points are general considerations and essential as pre-requisites to the public health nurse's general insight into the mental hygiene clinic. There naturally follows in your mind the question: "What does the clinic do in regard to the findings of its elaborate examination procedure?"

THE NURSE TAKES PART

Treatment of the unadjusted individual cannot always be carried out

within the clinic itself. Treatment plans often mean a manipulation of the environment and the effective treatment of any mental hygiene clinic is dependent on the close coöperation of all of the community facilities, schools, courts, social and health agencies, group services and institutions. The problem child in the home may be entirely the result of the extreme over-solicitousness and over-protectiveness of the mother, whose attitudes come primarily because of a constant state of anxiety and worry brought about by her own physical condition. Little can be accomplished in overcoming her attitudes toward the child until the basic underlying physical cause in herself is given the proper care. Chiding the boy for his misconduct in the light of his sick mother is not the proper approach to the problem, although this may be the one thing you may be strongly tempted to do, in your zeal to bring comfort to the harried mother.

This brings up an important point, namely: one's attitude toward the problem. Is it to be of an investigatory scientific nurse or is it to be the harried pent-up futility of aggravation. This of course is dependent entirely on yourself. It is your subjective attitudes usually which will determine the existence of a problem. Most of us discipline or over-react to a situation only when we become emotionally involved and, from the standpoint of the unadjusted patient, this reaction on your part may be the very attitude which further antagonizes him.

Time and again it is demonstrated that the behavior of certain children is carried on primarily because of the satisfaction which the child gains in successfully frustrating one of those superior persons called adult. This is behavior which the child used as an infant, which was probably thought cute, or at least catered to by the parents. As the child grew older, the parents found themselves in considerable difficulty in keeping up with his increasing demands. When they will no longer cater, naturally the child rebels and in the eyes of the parents becomes the ungrateful problem child. The child may well be a problem but merely agreeing with the parents that the child should be punished is not planning a program to eradicate the underlying causes. This will only come about through seeing the whole situation and bringing about in the parents a willingness to face their own share of responsibility in the development of the problem, and their own need of great effort in the continued handling of the situation. This same can often be said too, of the school teacher, the group leader, or the institution supervisor. Changing of attitudes is a large part of the treatment work of the mental hygiene clinic—attitudes within the patient and attitudes existing in the environment. In your home visits, then, yours must be an objective attitude, one which will allow you an unbiased evaluation of the emotional factors existing within that home.

Several lesser, though important, considerations involve the nurse's knowledge of mechanical details as to the working basis of the clinic. Mental hygiene clinics vary somewhat as to their own method of working in the community. Not all communities are able to support a full time psychiatric clinic. Some communities rely on the traveling clinic, a unit consisting of social worker, psychologist and psychiatrist emanating from some central bureau and establishing itself in a community for a short period of work only. To make use of such a clinic one must know in advance when the clinic will be available and what the possibilities are in the way of securing appointments for your clients. Other communities make use of a permanent clinic which in turn uses the part-time psychiatrist or psychologist. Naturally the number of cases which can be seen are limited and each clinic makes use of its own clearing system to determine what patients may be best benefited by the clinic. The permanent clinic usually employs an executive secretary or chief social worker who can supply information as to the refer-

ring of cases to the clinic and general advice as to the nature of the clinic study. Then if your case is accepted you may be assured of as complete a study as is possible with the facilities which the clinic has. An accurate appointment system is an important point because the clinic psychiatrist's time is usually scheduled far ahead. All too frequently a social worker in some outlying district will arrive at the clinic with a car full of patients, children and their parents, and will expect a full clinic study and discussion with the parents in regard to the examination findings as well as individual discussion with herself. The parents have probably been subjected to considerable difficulty in getting to the clinic, and it is too bad to have to return them home unsatisfied. Yet having to give them information on the basis of a superficial study or an incomplete study, likewise does not facilitate the best working plan of adjustment for the individual. In other words, before bringing a case to the clinic, find out what procedure is necessary.

THESE FACTS WILL HELP

Certain initial information which you can obtain through following the clinic history questionnaire will be of great value.

The psychological examinations do or do not take place on the same day as the psychiatric examinations.

Parents or responsible persons are not seen until after the clinic conference treatment plan has been discussed which may or, in most instances, may not be the same day as the psychiatric examination.

The clinic offers varying types of service. Consultation or orienting services are often possible.

The burden in carrying treatment may rest in large part on your own continued coöperation in working with the client and the clinic. This fact is not appreciated by many workers who, once having referred a case to the clinic, divorce themselves from any further responsibility. This is hardly coöperative case work, for it is on mutual acquaintance, friendship and understanding that coöperative work in public health and welfare depends.

WALTER BURNS SAUNDERS MEMORIAL MEDAL—1931 AWARD

The second award of the Walter Burns Saunders Memorial Medal for an outstanding service to nursing will be made this year. It will be recalled that the first medal was awarded posthumously to S. Lillian Clayton.

Distinguished for Service in the Cause of Nursing. These words below the name of the recipient mark this medal which is given by W. L. Saunders II of Philadelphia in memory of his father, William Burns Saunders. Any nurse who is a member of the American Nurses' Association and who has made to nursing a contribution such as is described below, is eligible to receive this award. "The recipient of the award is to be a nurse who has made to the profession or to the public some outstanding contribution, either in personal service, or in the discovery of some nursing technique that may be to the advantage of the patient and to the profession. The only kind of service excluded is that of writing."

How to Recommend Your Choice. If you have in mind a nurse who, in your opinion, is worthy of this award, submit her name either individually or through your state association of nurses. Your recommendation should state accurately the nurse's name, her address, her official position. The recommendation should "carry with it a complete statement of the professional background and accomplishments of the individual, together with a history of the achievement for which the award is to be made." Recommendations should be submitted to the American Nurses' Association, 370 Seventh Avenue, New York City; or, if preferred, to the president of one of the three national nursing organizations. All recommendations must be received by the Committee on Award or its representatives as described above before April 6, 1931.

Committee on Award: Elnora E. Thomson, R.N., *President*, American Nurses' Association; Elizabeth C. Burgess, R.N., *President*, National League of Nursing Education; Sophie C. Nelson, R.N., *President*, National Organization for Public Health Nursing; W. L. Saunders, II, Esq.

The Work of Volunteers in the Schools of London

By Louise Strachan

Director of Child Health Education, National Tuberculosis Association

"BETWEEN six and seven hundred thousand children scamper home to tea every day from London's elementary schools. They scamper down every kind of street from the double row of little houses with spotless Nottingham lace curtains—so spotless that the windows can never be opened for fear of the smuts—to luridly exciting, noisy and often squalid streets lined with coster stalls, bringing life and hope if also sometimes trouble and anxiety into practically every home in them. They are the key to the hearts of those who live there, and hence the key to most of the social problems found there."

With these vivid words, Mr. G. H. Gater, Education Officer of the London County Council, sounds the call for volunteers to assist in making effective for the individual child the spirit of social responsibility and goodwill underlying legislation.

Lady Keyes, President of the Section on Women and Children and the Public Health at the 1930 Portsmouth Congress of the Royal Institute of Public Health, said in her presidential address on "The Voluntary Worker in Relation to the Public Health Service":

> "It is not too much to say that the public officials of England are inspired by the voluntary spirit to an extent perhaps unequaled in any part of the world. . . . School Care Committees may be said to have worked a revolution in regard to the well-being of elementary school children in London and elsewhere."

LONDON'S CARE-COMMITTEES

Every elementary school in London has a Care Committee composed entirely of voluntary workers. There is a small staff of paid organizers in each area, comprising about one hundred schools, and they train the voluntary workers until they are ready to work independently. The total number of these voluntary workers in London alone is between six and seven thousand. The personnel of these School Care Committees is made up of those who are interested in the children attending the school, such as the clergy of various denominations and their church workers, managers of boys' clubs, scout leaders, representatives of various specialized societies such as the Invalid Children's Aid Association and the welfare organizations of the district. In some cases, working men and women serve on the committees.

In the printed leaflet issued by the London County Council which sets forth the service volunteers can render in the development of each school child for worthy citizenship, the following description is given of "How You Can Help":

> "You can help by doing either personal or clerical work. By visiting the homes, you can enter into the parents' difficulties and coöperate with them for their children's good, and your knowledge of the home can also be of great assistance to the teachers. If you cannot do visiting, you can help with the clerical work which forms the necessary basis for personal work.
>
> "By attending medical inspections you can help the parents with advice on how to obtain treatment. You can also visit the absent mother and explain to her the doctor's report.
>
> "By investigating with sympathy and understanding every case of suspected undernourishment, you can discover the cause and help to find the remedy.
>
> "The Care Committee, finally, is the means of bringing together the child, the employment expert, the club leader and the evening school teacher. Will you not help to form the future of those who will make the future?"

The Care Committee worker acts as the link between home and school, and interprets to the home the Acts of Parliament concerning child health, in terms of human fellowship and under-

standing. Quoting again from Mr. Gater's call for workers—

"Sections 82–85 of the Education Act make it possible to feed a hungry child, but it requires the best that is in human nature to keep his father from losing heart when he is out of work, or his mother from lowering her standard of home life. Sections 80 and 81 provide for the medical inspection of school children, but it requires great powers of persuasion and sympathy to give courage to the parents who have a horror of allowing their child to 'have his throat cut,' which is their picturesque way of describing the very simple operation for the removal of tonsils and adenoids, to overcome prejudice against the wearing of spectacles, or to bring home the importance of regular daily attendance at the minor ailment center for months if discharging ears are to be cured.

"Then there is the Children Act, designed to protect children from unscrupulous parents. It requires powers of judgment to discern where parents are sacrificing their children's well-being through culpable carelessness, and where through misdirected love. The child's and the parents' interests are really the same, and it is for the care worker to convince rather than convict."

The organization of School Care Committees was begun by the London County Council in 1909. The managers of the schools were asked to appoint two or three of their members to form nuclei of the new committees and other voluntary workers were appointed by the Council, largely from among those already interested in the work, but supplemented by others who responded to a wide appeal which was issued. A staff of organizers of care work was also established to coördinate the work of the volunteers and to give guidance to new members of care committees. "The continuity of sustained effort displayed by these committees, chiefly in unobtrusive ways, in the service of children is admirable and no voluntary service within the manifold activities of the school medical service is more beneficial or remunerative," wrote Sir George Newman, Chief Medical Officer of the Board of Education and of the Ministry of Health.

THE CARE COMMITTEE IN ACTION

In London every school child has a medical inspection four times during his school life. The first one is made when he enters upon his school career; the second, at the age of eight; the third at the age of twelve, and the final one, when he is about to leave school. The parents are invited to attend these medical inspections. From figures available for 1927, 65 per cent of the children examined that year were accompanied by their parents. Always a member of the Care Committee is present at these inspections. The arrangements for medical inspection are in the hands of the Divisional Medical Officer. If the secretary of the Care Committee finds it impossible to arrange for a member of the committee to be present on any particular day of the week, she is expected to notify the Divisional Medical Officer through the district organizer, and efforts are made to suit the convenience of the Care Committee. Ample notice is given the secretary by the district organizer of the dates of coming inspections so that any changes which may be necessary can readily be made.

Twenty-five routine cases are seen at each inspection and in addition, a limited number of special cases may be presented. Children who are found to require treatment are re-inspected the following term for the particular defect noted. If the defect is cured they are discharged, but if further treatment is required they are referred for reëxamination at the end of another six months. It is interesting to note that for the routine examinations, the children are stripped to the waist and shoes and stockings are removed. The care committee worker who is present at the inspection has the opportunity for a friendly talk with each parent to discuss the advice given and the best method of obtaining any necessary treatment.

The same general plan is followed for the dental inspections which are made by dentists who visit in rotation the schools allocated to their centers for the purpose of inspecting the mouths of the children and addressing the parents, who are invited to be present at the dental inspection, on the care of the teeth. Here again a care committee member is present.

SERVICE FOR "LEAVERS"

The service rendered to the children leaving school to enter industry is noteworthy. The duty of advising these children in London as to suitable employment devolves on the Ministry of Labor. Twenty-one Juvenile Advisory Committees have been formed for this purpose, and a coöperative plan has been worked out between the London County Council and the Ministry of Labor. The secretary of the Care Committee arranges with the district organizer and the head teacher for conferences at which the children who are leaving school may be interviewed. The dates are arranged so that the officers of the Juvenile Advisory Committee of the Ministry of Labor may attend. Never more than 15 children are interviewed at a time. Additional conferences are arranged if the number of children leaving school is too large to be cared for adequately in one conference. The head teachers prepare for the secretary of the Care Committee a report on each of these children which gives his standard of attainment in school work, observations concerning conduct, character, ability, and any special aptitude, and the medical officer's last report on the child. A notation is made of the sort of employment recommended by the head teacher and desired by the scholar. These do not necessarily agree! In the meantime the Care Committee reports on the home circumstances of the child, and the father's occupation; the wishes of the parents regarding their child's employment, and the club or organization with which the child may be affiliated. The medical records of all these children are carefully studied for any special defect or delicacy which would have a bearing on the type of employment under consideration.

The parents of the children leaving school receive a special letter of invitation to attend the conference. A representative of the London County Council is also invited to give advice on continued education. The conference, then, consists of all those interested in the child's welfare, the parents, the Juvenile Advisory Committee member, interested in his employment; the London County Council's representative, interested in his continued education; Care Committee members, head teachers, and the district organizer.

The "agenda" giving subjects for discussion for one of these Conference meetings is worthy of note:

> The kind of work for which the child is best suited and how it shall be obtained.
>
> The type of continued education desirable, *e.g.*, evening institute, day continuation school, trade school, etc., and its relation to the work chosen.
>
> Recreation and links with other organizations.

At the end of each interview, the Chairman sums up, so that the advice of the Conference is quite clear to the parent and child. When the child has been seen, the necessity for special supervision is carefully considered and entered on the proper form—a "School Leaving Form" issued by the Education Officer's Department of the London County Council on which all the information already referred to concerning the child is entered.

In order to avoid overlapping, all cases for which the Juvenile Advisory Committee wish a home visit to be made are referred to the Care Committee which is asked to coöperate by obtaining the desired information. The supervision of the children after they leave school is known as "After-care." Some of the Care Committees have worked out the following methods:

> After-care through clubs and parish organizations.
>
> Care Committees who use this method have a working arrangement with leaders of neighboring clubs for notifying them of children leaving school and for effecting introductions when necessary. By this means it is also often possible to get a supervisor who will be a real friend to the individual child.
>
> Work on special cases.
>
> Care Committees make a definite plan of helping those children where a recommendation that supervision is necessary has been made.

Review of "leavers."

Care Committees arrange for a visit to be paid the following term to every child who has left school, only carrying on cases for supervision after this where plans discussed at the Conference have not materialized.

Evening institutes.

The representative appointed by the Care Committee visits the evening institute the following term and reports an enrollment of "leavers," the Care Committee visitors following up absentees when possible.

Social evenings, etc.

The Care Committee preserves contact with the children by means of social evenings and old scholars' clubs.

Is not this, indeed, a "Great Adventure," this work with and for potential citizens? Pasteur said, "When I see a child he inspires me with two feelings: tenderness for what he is now, respect for what he may become hereafter." The future of our children is our greatest concern. Is not the splendid service of the volunteers serving on London's School Care Committees*—an army of more than 6,000—a challenge to us in America to make more and better use of the talents and resourcefulness of those who would gladly serve as volunteers to assist in the development of *our* potential citizens if they were but shown the way?

* School Care Committees are not confined to London alone. They are organized throughout Great Britain.

Comments on Health Center Procedure

BY ANN B. CHRISTMAN
County Nurse, Vilas County, Eagle River, Wis.

Editorial Comment: We welcome the discussion of any article printed in this magazine. We believe Miss Christman has made some excellent points. We hope some other reader will wish to carry the discussion further. For instance, should not the nurse be with the physician throughout his examination of a child? Is not one volunteer enough for a single doctor-nurse conference? If no volunteers are used, is not a splendid publicity avenue closed to the agency? Does the use of volunteers at conferences limit itself to urban communities? We urge readers to share the results of their experiences for the benefit of all.

I HAVE read with much interest, the article "Health Center Procedure" appearing in the October, 1930, number of THE PUBLIC HEALTH NURSE. I cannot refrain from presenting a divergent point of view from that of Mrs. King on a point upon which she has placed considerable emphasis, namely, the importance of using volunteer lay workers in the administration of the health center.

Here in Vilas County, in northern Wisconsin, we have had maternity and infancy health centers for eight years. We have held them in rural and semi-rural communities under conditions which probably parallel the conditions confronting the Oregon health centers. We have tried out, very carefully, both methods of organization, first with the volunteer lay workers, and later, without, and our decision decidedly favors the latter method. When I say our decision, I mean that of the doctors, the nurse, and most important of all, the mothers. For after all, unless we satisfy the mothers, our centers will not be the success which we hope them to be.

When we first started the centers, the personnel included the examining physician, the county nurse, and three lay workers serving gratuitously. It was the duty of one of these workers to meet the mothers at the door and assign each mother a place and a number; the second volunteer wrote histories and prepared the home card; the third weighed, measured and charted.

With this method, we were never able to eliminate noise and confusion. Looking back over those early confer-

ences, I feel that the bad feature was this—there was never enough for these lay workers to do to keep them continuously occupied. Any one familiar with the functioning of a baby center knows that it is going to take the examining physician three times as long to examine each case, as it takes to weigh, measure, chart and record each one.

Given three lay workers, or even two, and the result is that they are kept busy less than one-half of the time. It is practically impossible to keep them steadily at their posts, and prevent them from mingling with the mothers and children, in their unoccupied intervals. Insistence upon the requirements will only mean hurt feelings, resentment, and failure to come back to help at subsequent conferences.

After trying all methods, we have evolved a system which runs smoothly, and eliminates altogether the need of depending upon volunteer workers.

We have two rooms—one large room for the nurse and a smaller room for the doctor. The nurse's room has a row of seats at one side for mothers. Behind a screen, on the other side, are the desk, chairs for mother and nurse, scales, and other necessary equipment. As one mother passes into the examining room, the nurse knows that she will be there for at least fifteen minutes. The nurse calls forward the mother whose turn is next, who takes a seat beside the nurse's table. The nurse takes the history, or makes the necessary entries on the record card, if it is a return case. This takes five minutes at the most. Then, while the mother undresses the child, the nurse makes out the home card, ready for the examining physician. This takes five minutes more. The child is weighed, measured and charted—three minutes more. And there is always time, after these preliminaries, for the nurse to step into the examining room to hear any request or instructions the doctor may have to give, as to the case he is examining. Then, as that case is dismissed, the prepared mother and child come in, and the cycle begins over again.

All this machinery is satisfactory from the standpoint of the nurse and the physician. From the mother's standpoint, the method has one tremendous advantage — privacy. The presence of volunteer workers in a city center, where they are strangers to nearly all of the mothers, presents no objection from this angle. But in a rural community, where everyone knows everyone else, the presence of the non-professional worker takes away much of the professional privacy which the center should and must have.

The mother is entitled to have the entire routine of the examination conducted with the utmost privacy. With lay assistants, we cannot always give the mother the assurance that the person who takes the history will treat the information with professional confidence. Even the best type of volunteer worker often overlooks or forgets the importance of this aspect of the center. No amount of emphasis on the part of the nurse can completely guard against and prevent occasional violations.

The mother who realizes that her child is not doing well, that she is underweight, puny, or retarded, and is therefore most in need of health advice, will be much more reluctant to appear at the center if she knows she will have to run the gauntlet of two or three curious neighbors or acquaintances who are assisting. In a visit to a doctor's office a mother would be indignant if she were required to undress her child before her neighbor Mrs. Jones, have it weighed and measured by Mrs. Smith, and have the history taken by Mrs. Brown. Should her visit to the doctor at our conferences or clinics be regarded in any different light from her visit to a doctor's private office?

Over the Back Fence

By Hassie A. Towler
Educational Secretary, Boston Tuberculosis Association, Boston, Mass.

ONE item on the program for Boston Better Homes Week last year read: "Demonstration at 34 Sawyer Street. A basement kitchen, back yard with board fence being used by a family which includes a man, woman, and four little children—improved to show an attractive and practical basement kitchen, a clean yard with play space and sand table for the children, a little grass plot, vines and flowers for the mother, and a painted picket paling fence through which the sun can shine and which the man can keep in repair." A public health nurse employed by the Boston Tuberculosis Association to do health education work in Ward 9—a section of the city having a high mortality from tuberculosis and a large Negro population—had charge of this demonstration.

The Better Homes organization donated fifty dollars for the project, which was planned and was carried out by the Boston Tuberculosis Association.

The kitchen and yard chosen were admirably suited for the purpose, being located on Sawyer Street, the back yard facing Kendall Street alley. A telephone to the local foreman of the street cleaning department resulted in the immediate removal of sixty barrels of refuse from the back yard, for which the owner was so grateful that he readily consented to tear down his old board fence, replacing it with the new four-foot pickets purchased with a part of the fifty dollars. Having just secured a job after a jobless winter, he was obliged to work "after hours" on the fence; but the offensive boards were taken down, sawed into stove wood and stored away. The new pickets actually became a fence, which was painted a delightful green. The surrounding board fences in all stages of decay were treated to a generous coat of whitewash by the Neighborhood Get-Together Club, a group of people organized by the Boston Tuberculosis Association and pledged to promote the health and cleanliness of the neighborhood.

People in the block began cleaning out their yards, and much to the dismay of the city ashmen, stacked their refuse in the alley. The ashmen, against their custom, brought shovels and wheelbarrows and cleared the alley. Then other people got busy and cleaned their yards, and, having filled the ash cans, did what their neighbors had done, piled the overflow in the alley. By special request, the ashmen came once again.

Having cleaned the yard at 34 Sawyer Street, built and painted the fence, the question of flowers and grass presented a problem, as the ground in the back yard seemed to be made entirely of ashes. The head of the City Park Department was approached with the result that a load of loam was contributed—enough for a border around the picket fence, and some to spare for the neighbors who had become inoculated with the desire to clean up, and were showing definite symptoms of yard improvement. A trip to a friend of the Association, living out of town, netted shrubs for the yard—lilac, forsythia, and dahlia bulbs. Then began the quest for bricks to pave the yard. Again the City came to the rescue and 1,500 bricks were unloaded on the sidewalk in front of 34 Sawyer Street, the alley having no opening for teams. For hours the perplexing problem of "how to get the bricks from the sidewalk to the back yard" seemed to have no solution.

It was the day before the demonstration. An enterprising neighbor who had grown accustomed to an alley strewn with refuse, and back yards piled high with waste, could not, however, endure the added insult of bricks on the sidewalk. She, accordingly,

registered a complaint, and soon an official of the law was ringing the doorbell and demanding that the bricks be removed—and they were. This seemed to be the necessary stimulus. Doors were thrown open, and through the hallway, down the stairs, into the basement, and out into the yard went the bricks, a few at a time, carried by the neighborhood men who were just returning home from work. Laying the brick seemed an easy matter. The Prendergast Preventorium gardener has already provided the needed bags of sand, and so the yard was paved.

A little at a time, meanwhile, the kitchen had been painted and pruned of unnecessary furnishings. Gradually, the little mother had acquiesced in having her pots and pans hung where she could reach them easily instead of stacking them inconveniently away. She began to like the cream walls, green wood-work, black floor, and dainty flowered curtains, and proudly showed the kitchen to neighbors who watched the work with growing curiosity. The school playground supervisor provided a sand table for the children, bean bags and other games, with which the youngsters began immediately to give a free demonstration, and one could readily see the wisdom of planting only hardy shrubs, and putting those near the fence so that the yard space—fifteen by twenty feet—was free for play.

The day of the demonstration, May 1st, dawned clear and sunshiny, as is confidently expected of every May Day. The hour for "open house," found Sawyer Street alive with suppressed excitement. Things that had cluttered the fire escapes and back windows for months had mysteriously disappeared, and in their places stood geraniums, blooming a gorgeous red, green potted plants, and a lone window box, which had been hastily removed from the front and put in the back window in honor of the occasion. Far up the alley, people began looking out of windows, craning their necks to see what was going on in the back yard at 34 Sawyer Street, and they were repaid for their efforts. The new green picket fence stood out prettily against the whitewash on the surrounding high board fences; the two kitchen windows were resplendent with pansy-filled window boxes; the lilacs and forsythia were putting forth their newest green leaves; golden yellow daffodils stood among the tea things on a long green covered table set in the yard, and the two littlest children were making the most of the sand table while their mother was being introduced to the guests. Ice cream, a gift of the playground supervisor, was served, as long as it lasted, then tea and little frosted cakes. Every family on Kendall and Sawyer Streets had received a written invitation, which a large number accepted. Bashful young husbands, painfully aware of their "Sunday clothes," gravely inspected the kitchen, asked "paint" questions, and looked with interest at the yard. Mothers with one or two children, faces shining with all the joy of an unexpected holiday and "sweet" soap, gave their undivided attention to the yard, which no doubt seemed an oasis of cleanliness and beauty in a desert of yards serving solely as a catchall for refuse. The Boston Tuberculosis Association Executive Secretary found her rôle of hostess a busy one.

The demonstration did not close on May 1, 1930. The little woman who accepted the gift of an improved kitchen, back yard and fence, through the courtesy of the Better Homes and the Boston Tuberculosis Association, has consented to allow the neighbors the privilege of inspecting her kitchen, when it does not interfere with her home routine, and to keep her yard and flowers so that this will be a permanent demonstration in a vicinity where it is so badly needed, serving as an incentive for cleaner living conditions which are essential to good health.

County Volunteer Service

By Elba L. Morse, R.N.*

IT was three years ago when I first met with the Royal Oak Township (Michigan) Nursing Committee. Five members came to meet the new supervising nurse, their plan being to give their approval or disapproval, and then go on their vacations and leave the work to her if they felt she qualified.

During the first meeting it was decided that there were some definite things this committee should do, and that they should start at once. First, each member was to study the service cards of the Visiting Nurse Association to familiarize herself with this information, and carry extra cards in her purse; each member was to ask five people each week if they had heard about the work of the visiting nurses, give out cards and explain the service, endeavoring to reach various groups—the financial supporters as well as those needing service.

During the first month, the nurses were called upon to answer many questions that were puzzling the committee members, and interest in the work grew daily. At the second monthly meeting, each committee member gave a personal report. All were surprised that so few people in the community had any idea what the visiting nurses really did, but admitted that they had learned much and felt it was worthwhile. Two things were decided upon at this meeting: first, to enlarge the committee. Several names were suggested of women who were known to be interested, and the committee was authorized to invite them to attend the next meeting with a view to joining. The second suggestion was that each member plan to spend at least one-half day at the visiting nurse's office and to give a report of the day at the next meeting, and to continue to contact five people a week to tell about the service.

At the third meeting, new members joined, and the subject of layettes was discussed. A call had come in for a layette, and the chairman of the nursing committee and the supervising nurse had gathered up garments from different places while a baby was being bathed and waited for his clothing.

The chairman of the nursing committee had, during the month, invited the welfare chairmen of the five women's clubs of the township to attend the meeting. She inquired regarding their program and asked if their clubs would make five layettes each for the Visiting Nurse Association and invited the chairmen of the welfare committees to be members of the nursing committee. This arrangement has worked out very well, and each year a letter is sent to each club, and when the welfare chairman is named she automatically becomes a member of the nursing committee. A report of the layettes and also of the entire work of the Visiting Nurse Association is sent to each club and given by the welfare chairman.

Infant and Pre-School Interest

The next project that the committee considered was the infant and preschool clinics. These clinics were being conducted in the schools so the committee members visited the clinics in their districts. The nursing committee chairman and the supervising nurse talked at the various Parent-Teacher Association meetings, requesting that each appoint a health and hygiene committee as a standing committee of the Association. Some were already functioning. We asked that the chairman of each committee be a member of our nursing committee and that this committee appoint two hostesses to serve at each infant and preschool clinic. This was a job that took much time, but

* Miss Morse was formerly supervising nurse, Royal Oak Township, Michigan. She is now with the Children's Fund of Michigan.

which has worked out satisfactorily. We now have sixteen clinics a month in the township, and average two hostesses for each clinic. The Visiting Nurse Association report is sent to each Parent-Teacher Association. We now have a sub-committee on clinics that arranges for instruction of new hostesses and sees that the nurse is not left with two new hostesses. It is the tendency to have one hostess in charge of each clinic with a change of assistants. They make out histories, weigh and measure, and assist the mothers in dressing the children. They give the friendly and hospitable air to the clinic that is hard for the nurse to convey when she is busy assisting the doctor.

In return for these services to the regular clinics, the nurses help the Parent-Teacher Associations with their May-Day round-up. This has been worked out very carefully with all nurses in the territory; school and tuberculosis nurses and nursing committee. One member of the Visiting Nurse Association has been appointed to the Parent-Teacher Association council so there is a close affiliation in all health work.

The motor service has grown naturally from our need to take children to clinics, and crippled children to special clinics and hospitals. This has developed with a separate committee but the chairman is a member of the Visiting Nurse Association and gives a report at our monthly meetings.

Our crippled children's work has grown from forty to one hundred and thirty-seven cases under treatment. There are some committee members who are intensely interested in this work, and give a definite number of hours to it. We have felt that we all needed the stimulation that comes from this work, and have kept it a part of our whole committee, rather than making a special sub-committee. A visit to the special hospitals doing crippled children's work has been made by the committee, and slides and pictures and talks by specialists have been given. The children have been taken to special entertainments; theater and special parties have been given for them in which the committee members have taken an active part.

EDUCATIONAL WORK OF THE COMMITTEE

The first year a list of questions was made regarding the resources of our community, *e.g.*, How do we care for an indigent medical case? A case of illegitimate pregnancy? What hospitals are available to the crippled child? What is the state law regarding a crippled children's special school room? What are our facilities for care of tuberculosis cases? Each committee member chose a question which she studied and reported upon to the committee.

Visits to the different hospitals and institutions in the county have been planned. Classes in "Home Hygiene and Care of the Sick" have been conducted, and many of our committee members have taken the course. New members have been found through these classes and became interested in the service.

This third year each member of the committee has given at least one talk to a group of her own choice on the work of the visiting nurses. We have a chairman of publicity, herself a writer, who has written some very interesting feature stories.

During the May-Day round-up, we needed more nurses. One member of our committee, a married nurse, conceived the idea of a Married Nurses Club. Through her efforts, about forty married nurses, of whom we were not aware, were located in our midst. They volunteered for the May Day program, and this was followed by a tea and a few special meetings. They formed a sub-committee that we could call on for many things, for special relief in times of stress, and for some hourly nursing. A delivery service, that we were unable to offer, was worked out by three of the married nurses who were willing to take the individual cases that were referred to them. The patients made their own arrangements with these nurses and

then the visiting nurses gave postpartum care.

A cardiac case has been given to a married nurse to supervise. She visits her case each month, goes to the hospital or clinic with the case, and gives the report to us. This is a volunteer service. We feel that the cardiac case needs professional guidance, but our own staff at present is overloaded with pressing cases. It is a great help to have this volunteer professional service, and our married nurses are enjoying it.

The third year a member of our committee, who was very carefully chosen, visited every doctor in our territory, by appointment if possible, gave him a new service card, and discussed the work with him. This was a very worthwhile and gratifying piece of work, and brought a better understanding and much commendation of the work we are trying to do.

Our committee meetings are monthly, the first Monday, from two to four o'clock. Our special committees report each month. Sometimes a special committee will give a program: The layette committee asked each member to bring a guest and after the reports were given, played bridge. The proceeds went for material for night dresses.

One member of the committee has charge of surgical dressings. She starts the first person to work when she arrives at the meeting, so they all work as they listen. Our surgical chairman also makes appointments with the church groups and various clubs, who devote at least one meeting to making dressings for the Visiting Nurse Association. A speaker is usually requested for this meeting and it is another avenue for publicity.

The welfare committee of the family case-working agency gave the Visiting Nurse Association a very happy surprise in the form of a sheet shower. Every individual or organization gave a sheet. When the nurse supervisor was ushered in, every one had a sheet over her head and was bowing to her; 96 sheets and 13 pillow slips were added to the loan closet that day!

MY NURSE—BY A SMALL BOY

Oh, she comes walking every day,
Walking quickly down our street,
I run and hang upon the gate
So we'll be sure to meet.

She wears a pretty, blue, blue dress,
And though she's awful old and wise
Happy little spiky stars
Go jumping in her eyes.

And if it's stormy there I stand,
And watch behind the window pane;
She tilts her bumber-shoot and calls
Laughing through the rain.

I don't know where she goes each day,
And no one seems to know her name;
But I heard some kids call her "Nurse"
So I just do the same.

She walks so straight and very fast;
She holds her head away 'way up,
But she's not proud—well I guess not—
She cured my yellow pup.

The Health Broadcaster, Ohio

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

THE ADVISORY COUNCIL DINNER, AND THE JANUARY MEETINGS OF THE N.O.P.H.N BOARD OF DIRECTORS

We wish every member of the N.O.P.H.N. might have peeked in at our meetings held January 20 and 21! Progress in public health nursing was the keynote in all of them.

These meetings were notable for several reasons. There was wider representation than usual from all parts of the country: From Rhode Island to Georgia, Minnesota to Arkansas, Oregon to Colorado, including the Presidents of four State Organizations for Public Health Nursing and Miss Thomson, President of the A.N.A.

The Advisory Council of the N.O.P.H.N. (see page 41 of advertising section for names) met on January 20th at an informal dinner attended also by the Board and members of the staff at which Miss Nelson presided. An historical and philosophical review of the N.O.P.H.N. by Miss Gardner, which she herself called a "snapshot," brought to mind the coming twentieth birthday of the organization in 1932 and placed before the Advisory Council such searching questions as "Are we headed right?" "Shall we decentralize? If so, how?" A panoramic view of the present program of the N.O.P.H.N. by Miss Tucker revealed the extensive activities of the organization, its large volume of accomplishments and the ever-increasing demands being made for its services.

Dr. Lee K. Frankel opened the discussion by the Advisory Council members by stating that he was present when "A group of school girls founded the N.O.P.H.N." He felt the organization had now passed safely through adolescence into maturity. It should be stimulating and encouraging to every public health nursing group in the country to know that Dr. Frankel, Prof. C.-E. A. Winslow of Yale University, Dr. S. J. Crumbine of the American Child Health Association, and Dr. W. F. Snow of the American Social Hygiene Association, all commended highly the public health nurse as an essential agent in the whole public health movement, and described the N.O.P.H.N. as an indispensable organization. Certain suggestions of this Council for the future strengthening and extension of our work were received with deep appreciation and will be a valuable guide to the Board as to next steps.

An innovation was made in the Board meetings themselves in that the first half day was devoted largely to presentations by each member of the executive staff of her particular activities and program. This served to acquaint the Board members more definitely with each staff member and with the actual work each is doing.

THE BOARD MEETINGS

Of first importance to our members will be the vote of our Board that we move from "370" to "450" Seventh Avenue. This move is occasioned by the need of the other agencies in the National Health Council for additional space and can be made economically and advantageously at this time. Our own recognition of the value of being housed with the other health agencies has overcome our contentment with our present space and our highly-prized view over the Hudson. During Miss Nelson's presidency we shall, appropriately enough, be housed in the "Nelson Towers" to which we shall move about March 15th.

COMMITTEE REPORTS

The *Education Committee* reported three accomplishments:

"The qualifications for public health nursing positions for 1935" has been sent to the American Public Health Association for final approval.

"The Objectives and Functions of the Public Health Nurse in School Nursing Services" has been published. (See THE PUBLIC HEALTH NURSE for January, 1931.)

The content of a post-graduate course in industrial nursing has been prepared and sent to each course director.

The *Magazine Committee* announced plans for a new blue cover for the magazine and the addition of a "Contributors Column" giving biographical notes regarding the authors of articles. Later when funds and circumstances permit, the name of the magazine is to be changed to "Public Health Nursing" as more truly indicative of the scope of the magazine which goes beyond the nurse herself, to the service given to the community and to the participation of the lay public.

The *Organization Committee* (formerly *Revisions Committee*): A conference of State Supervisory Nurses, Presidents of S.O.P.H.N.s, and Chairmen of P.H.N. Sections, is planned for the late Spring at some central location near Chicago to discuss public health nursing on a state-wide basis. State Health Officers have widely endorsed the plan and enough nurses have indicated their interest and ability to attend to make the meeting a reality.

A "Manual of Procedure for S.O.P.H.N.s" is to be sent to each Branch, containing "Suggested Rules for Lay Sections of Branches" as well as "Suggested Membership Routines." It is anticipated that two or three branches will try out a new scheme for joint S.O.P.H.N.-N.O.P.H.N. membership.

The *Service Evaluation Committee* report given by Dr. Haven Emerson, its chairman, stated that the time study of 24 visiting nurse associations and the text of the revised Visiting Nurse Study Report will soon be ready for final presentation at a meeting of the Committee at which representatives of the insurance companies will be invited to be present.

The *Field Studies Committee* is undertaking the preparation of a statement of the objectives in every phase of public health nursing, using that prepared for the New York State Health Commission Report as a basis.

It will be generally remembered that Miss Tucker was chosen by Governor Roosevelt as Chairman of the Public Health Nursing Committee of the New York State Health Commission. Her Committee has completed its report and sent it in to the Commission.

The Field Studies Committee is also considering plans for a survey of the administrative practice of public health nursing agencies, and the content of their services.

The *Records Committee* is engaged in a review of N.O.P.H.N. records looking toward their future revision.

JOINT COMMITTEES

Social Hygiene: Through field studies, advisory service and institutes, the joint social hygiene program of the American Social Hygiene Association and the N.O.P.H.N. is reaching both official and non-official agencies. The National League of Nursing Education has been approached to assist in better preparation of the student nurse. It has been recommended to drop the term "social service nurse" as used in many social hygiene programs and to use instead the term "public health nurse," thus avoiding confusion with social case workers and tying up social hygiene more definitely with public health nursing.

Mental Hygiene: The joint committee with the American Association of Psychiatric Social Workers is giving direction and backing to the new program being started by Miss Gilbert, the first approach being a review of the mental hygiene programs now being conducted in public health nursing organizations throughout the country.

Reports of the joint committees of the A.N.A., N.L.N.E., and N.O.P.H.N. are to be given in the April magazine.

FINANCIAL STATEMENT FOR 1930

The figures that follow have been abstracted from the auditor's report, a copy of which is on file at headquarters. We will be glad to answer any questions from our members or give additional data relative to the report.

Although the total general expense, which it will be noted includes Biennial Convention expense, is approximately $8,000 more than in 1929, our income likewise increased, so that we closed our 1930 accounts with a margin of income over expense of $1,242.35. We were fortunate in having this increase in income, as with it the N.O.P.H.N. was able to meet, at least in a limited measure, the increased demands made upon the organization by local groups.

The expense of the service to Board Members and Extension was some $1,700 more than the income for 1930. This difference, however, was met by drawing on the surplus which this fund carries and which is available for current expense.

Considering the financial and economic conditions prevailing throughout the country during 1930, it is encouraging to note that our income remained surprisingly stable.

N.O.P.H.N. INCOME AND EXPENSE FOR 1930 AS COMPARED WITH 1929

	1930	1929	Increase	Decrease
INCOME				
Membership dues, individual	$14,646.00	$14,702.00	.....	$56.00
Membership dues, corporate	18,083.74	18,796.23	.....	712.49
Contributions	24,138.00	25,613.66	.....	1,475.66
Magazine	22,871.64	21,411.49	$1,460.15	.....
Reimbursements	8,144.19	3,365.46	4,778.73	.....
Convention	3,232.77	.....	3,232.77	.....
Miscellaneous Earnings	3,633.46	2,628.32	1,005.14	.....
Total General Income	$94,749.80	$86,517.16	$8,232.64	
Special Projects				
Service to Board Members and Extension	$10,000.00	$10,000.00	.....	.....
EXPENSE				
Affiliated Activities	$1,630.00	$2,721.66	.....	$1,091.66
Joint Vocational Service	4,000.00	4,000.00	.....	.....
Advisory Service (includes Library Service and Educational Propaganda)	44,456.95	35,926.60	8,530.35	.....
Magazine	27,646.86	25,772.45	1,874.41	.....
Statistical Service	7,254.09	9,817.92	.....	2,563.83
Financing (includes Routine Membership Renewals, etc.)	4,507.57	4,596.90	.....	89.33
Convention	4,011.98	.....	4,011.98	.....
Total General Expense	$93,507.45	$82,835.53	$10,671.92	
Special Projects				
Service to Board Members and Extension	$11,704.23	$6,164.44	$5,539.79	.....

J. V. S. NEWS

Joint Vocational Service is glad to announce that an extension of its work is being made possible through the permanent appointment of Helen Kienzle, R.N., as a second vocational secretary in public health nursing. Since last summer, while completing studies at Columbia University, Miss Kienzle has been temporarily assisting Miss Tittman in this field.

Miss Kienzle brings experience as a school nurse, visiting nurse, and child hygiene nurse. Her affiliations have been with the American Red Cross and the Wetzel County Board of Education in West Virginia, the Visiting Nurse Association of Oakland, California, and the Ohio Department of Health. She is a graduate of Ohio State University and of Lakeside Hospital School of Nursing, now the Western Reserve University School of Nursing. In addition to public health nursing work at Western Reserve University, she has had public health work at the University of California, Berkeley. Miss Kienzle's home was originally in Indiana.

During the first part of March, Miss Tittman will be in Boston for interviews. Appointments for employers, nurses, or students who wish to talk with Miss Tittman in Boston can be arranged through the national office of Joint Vocational Service, 130 East 22nd Street, New York City.

In January Miss Tittman visited Philadelphia, Ardmore (Pa.), and Trenton, and in December she made a trip to Albany and Schenectady, in order to confer with employers, interview candidates, visit organizations, and address several groups. Through the courtesy of Harriet Frost, course director of public health nursing, Miss Tittman had an opportunity to speak to the public health nursing students at the Pennsylvania School of Social and Health Work. She also led a discussion on personnel policies at a luncheon in Philadelphia attended by directors of public health nursing services.

At the time the March issue of the PUBLIC HEALTH NURSE was going to press, plans were being made by Lillian A. Quinn, director of Joint Vocational Service, to spend several weeks during March and April in southern cities in order to bring about closer contacts between the Service and the communities. Although the itinerary was not yet complete, some of the cities listed were: Richmond, Atlanta, Birmingham, Montgomery, New Orleans, Houston, Dallas, and, if possible, Nashville and Louisville.

JOINT VOCATIONAL SERVICE APPOINTMENTS

Helen Beaver, child health nurse, Speedwell Society, Bronx Unit, New York City.

Ruth Cummins, staff nurse, Association for Improving the Condition of the Poor, New York City.

Hilda Aulenbach, staff nurse, Health Department, Montclair, N. J.

Madeline Pitman, public health nurse, Old Town, Maine.

Edith Price, supervising nurse, District Nursing Association, Portsmouth, N. H.

May Livingston, general community nurse, Northern Westchester County District Nursing Association, Mt. Kisco, N. Y.

Amelia Engel, public health nurse, Rosebud Reservation, Parmalee, S. D., and Carrie Catlin, field nurse, Ft. Hall Agency, Ft. Hall, Idaho, both under U. S. Indian Service.

Abbie Whidden, community nurse, American Red Cross, Chapter, New Kensington, Pa.

Jeanette Salmon, superintendent, Shelter Home, Plainfield City Union Kings Daughters Day Nursery, Plainfield, N. J.

Sonia Ragins, staff nurse, Henry Street Visiting Nurse Service, New York City.

Carol Young, staff worker, social service department, Orthopedic Hospital, New York City.

Gertrude Stumbles, school nurse-teacher, North Country Community Association, Glen Head, L. I., N. Y.

Joint Vocational Service has assisted in the following appointments:

Della McNamara, district supervising nurse, Westchester County Department of Health, White Plains, N. Y., assigned to the County Committee for the Control of Cancer.

Eugenia Johnson, staff nurse, Visiting Nurse Association, New Haven, Conn.

Julia Wheeler, maternity, infancy, and child hygiene nurse, New York State Department of Health.

For other appointments, see page 157

Public Health Nursing Statistics
Units for Reporting

The following material is a continuation of the Definition of Nursing Services (THE PUBLIC HEALTH NURSE, October 1929, April 1930) prepared by the N.O.P.H.N. Records Committee as a part of a Manual of Statistical Practices of Public Health Nursing Agencies. The N.O.P.H.N. statistical service will be glad to answer questions in regard to these recommendations.

The two primary units of measurement for reporting the service given to individuals by agencies doing public health nursing are "Case" and "Visit." As public health nursing is part of the general medical field, the interpretation of these two terms is based on the technical definitions in the medical field.

CASE

Case refers to an individual under care for health supervision or for maternity care, or for a disease, in clinic or field service.

A. CLASSIFICATION OF CASE BY STATUS

1. *Cases Carried Over* are cases under care at the end of the previous reporting period that are to be continued under care in the current period.
2. *New Case* is one coming under care for the first time in the current year in a specified service. A case carried from the previous year is not considered a new case. Also classify as new cases:
   a. Individuals previously cared for in Morbidity Service in the current reporting year returning under care with a new diagnosis, or with a second attack of an acute disease, irrespective of the time that has elapsed since previous care.
   b. Individuals coming under care during the current reporting year in relation to a new pregnancy.
   c. Individuals who pass from one age group to another in Health Supervision Service.
3. *Readmitted Case* is one which has been dismissed within the current year and comes again under care with the *same diagnosis:*
   a. In Morbidity Service, with a continuation of the same disease. This applies primarily to chronic conditions needing care over a period of time.
   b. In Maternity Service, with the same pregnancy.
   c. In Health Supervision Service, belonging to the same age group.
4. *Dismissed Case* is one which is no longer under active care. An individual who has not been seen and given care within the period of a year should be dismissed.

B. CLASSIFICATION OF CASE BY SERVICES

1. *Case in Health Supervision* is one in which there is continuous supervision of the health of supposedly well individuals of any age group (exclusive of communicable disease contacts and suspects and maternity cases). Cases under this service are classified by age group, as follows: (a) Infant, (b) Preschool, (c) School, (d) Adult.
2. *Case in Maternity Service* is one to which care is given in relation to one pregnancy. Care given to a newborn infant as part of the postpartum care of the mother is also a case under the Maternity Service.

   An individual given care during more than one period of maternity such as prenatal and postpartum, represents only one case. There are two types of cases under Maternity Service: The mother who is given care during one or more periods of maternity, and the newborn infant.
3. *Case in Morbidity Service* is one in which care is given to an individual under or pending medical direction, or in which supervision is given to an individual suspected of having, or known to be exposed to, communicable disease. Cases under this service are classified into two main groups: (a) Non-communicable, (b) Communicable; with such sub-classifications of each as may seem advisable to individual agencies.

   As an example of one important subdivision, the tuberculosis field may be cited. All nursing service given in connection with a tuberculosis program should be counted in the communicable classification of the Morbidity Service. Most agencies will wish to sub-divide this service to show the number of: (1) Contact Cases or Suspect Cases, (2) Diagnosed Cases, (3) Post-Sanatorium Cases. These sub-classifications are defined as follows:

a. Contact Case is one in which the individual has recently* resided in close contact with an open** case of tuberculosis.
b Suspect Case is one in which the individual presents suggestive symptoms or signs of tuberculosis either from his history or physical examination, but for whom a positive diagnosis has not been made.
c. Diagnosed Case is one in which a physician has given a definite diagnosis of tuberculosis.
d. Post-sanatorium Case as used in connection with the appraisal form of the American Public Health Association, is one in which the individual has had at least three consecutive months' treatment in a sanatorium at any time.

Individuals Under Care Having More Than One Condition Requiring Care

When a more acute condition arises in an individual already carried as a case under any of the three services, Health Supervision, Maternity, or Morbidity, the case is carried under the diagnosis of the more acute condition.

A. TWO SERVICES INVOLVED

When the more acute condition is cared for by a service other than the one under which the case is being carried, the case is transferred from the present service to the service in which the more acute condition is cared for. It is entered as a new case, carried, dismissed and counted as part of this second service. After dismissal from the second service, it is readmitted to the first service and carried.

Example: An individual carried as a case under the Health Supervision Service develops pneumonia or some other acute morbid condition:

This case is transferred from the Health Supervision Service to the Morbidity Service and is entered as a new case under this latter service. It is carried, dismissed, and counted in the report of the Morbidity Service. At dismissal from Morbidity Service, it is readmitted to the Health Supervision Service.

B. ONE SERVICE INVOLVED

When a more acute condition arises in an individual carried as a case under the Morbidity Service, the case should be carried under the diagnosis of the more acute condition:

1. Ruling to determine when a new case is to be made:
   A diagnosis of a more acute condition will be a new case and have a new case record only when the new diagnosis is one that would not usually arise out of or follow the first condition.
2. Rulings to determine precedence in morbidity classification:
   a. An acute condition takes precedence over a chronic condition.
   b. Infections and communicable diseases take precedence over any other disease.
   c Acute communicable diseases take precedence over a chronic communicable disease.

STATISTICS ON CASES

The data in regard to cases may be compiled directly from the case records. Some agencies enter information regarding cases in a special book or on special cards and make their reports from these rather than from case records. While this practice may be necessary in obtaining certain information, it should be limited, as it means a duplication of recording.

The compiling of the data from the case records may be done by means of a tally system or by sorting and counting case records. When the tally system is used, a tabulation sheet or sheets should be drawn up, listing all the items to be tabulated. Under this plan, data may be compiled currently throughout any given period, or it may be compiled at some stated time.

When the figures are compiled by sorting and counting, this must be done *at stated times,* when all the case records used over the period of the report will be available for counting.

The usual periods covered in reports on cases are a month and a year. The figures are usually compiled monthly and summarized in an annual report.

* The period of time which represents "recently" is suggested as being within a period of five years.

** "Open" in this connection refers to any form of tuberculosis that is in a communicable condition.

NUMBER OF CASES UNDER CARE

Case Count is the number of different cases under care during any period.

Monthly case count is the number under care during a month.

Yearly case count is the number under care during a year.

I. General Nursing Services

The data suggested for the monthly report on cases under care of the general nursing service is as follows:

	Total number of cases (a)	Health Supervision Service (b)	Maternity Service (c)	Morbidity Service (d)
1. Under care at beginning of month				
2. New				
3. Readmitted				
4. Total under care during month				
5. Dismissed during month				
6. Transferred from service				
7. Under care end of month				

The total number of cases under care during the month (Item 4) is the sum of entries for 1, 2, and 3.

The number of cases transferred from service (Item 6) are those which have been transferred from one service to another because of a change in diagnosis. It is necessary to record only the number *transferred from* a service, and not the number *transferred to* a service, as all transferred cases are entered as new or readmitted under the service to which they are transferred.

The number of cases under care at the end of the month (Item 7) is the sum of the entries for Items 5 and 6 subtracted from the entries of Item 4. Any entry under column (a) will be the sum of the entires under columns (b), (c), and (d) in the same line.

II. Health Conferences and Clinics

The data suggested for the monthly report on cases under care in health conferences and clinics are as follows:

	Number of Cases
1. Under care at beginning of month	
2. New	
3. Readmitted	
4. Total under care during month	
a. Number attending clinic during month	
b. Number not attending clinic during month	
5. Dismissed during month	
6. Under care at end of month	

ANALYSIS OF CASES

The number of cases under care and the kind of case, as determined by the nursing service under which it is carried is given in the report on *Case Count*. Some agencies may desire more information than this regarding cases carried. Additional data may be compiled either for *New Cases* or for *Dismissed Cases*.

Since information regarding individual cases will not be complete until the case is dismissed, and also because it is not possible always to obtain certain information for new cases, such, for example, as diagnosis of morbidity cases, it is recommended that the analysis of cases be made on the basis of *Dismissed Cases*.

It is recommended that an analysis of *Cases Under Care* be made at stated intervals by agencies in which cases are under care for long periods of time and are not dismissed, such as in health supervision and certain phases of communicable disease control.

The data regarding cases which are to be compiled monthly or at other stated intervals, will depend on the needs of an agency.*

* Suggested outline for a detailed analysis of cases may be obtained from the N.O.P.H.N.

YEARLY REPORT

The report of number of cases under care in a year for both the General Nursing Services and Health Conferences or Clinics will be as follows:

Yearly Case Count

1. Cases carried from previous year to beginning of current month
2. Sum of new cases admitted each month (exclude readmitted cases)
3. Total number of cases under care during year

The yearly report on the Analysis of Cases for the General Nursing Service will be the sum of the monthly analysis of cases for each month.

(To be continued in April)

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

The Volunteer of the Junior League and Public Health Nursing

BY KATHARINE GAMBLE ROGERS

Field Secretary, Association of Junior Leagues of America, Inc.

SHALL we concern ourselves with Junior League volunteers, and if so what can be expected of them? The group consists of twenty-two thousand young women scattered all over the country with leisure, interest, tremendous energy, and the best of intentions. They are anxious to be of service and are waiting to be shown how. Are we going to let them flounder or are we going to use our imaginations, time, and our best brains to guide them in the paths which our professional experience has shown lead to the best methods of serving the community? Can we not form a partnership whereby staff and volunteer members of a society mutually recognize their complementary contributions?

First of all, let us have a picture of the organization with which we are dealing. Due to the avidity of society editors, the public has heard more about Junior League money-raising ventures than its philosophies and work accomplished. Philosophies have always been difficult for young people to articulate, but throughout their development in the Junior League one can trace the underlying principle of community service.

From a brief history of the Junior League we can clearly see a fluidity of purpose. In 1901 through a desire for service on the part of eighty New York debutantes several committees were formed to give these girls an opportunity to do what they could in the field of community service. In 1907 Boston started a Junior League, and by 1912 the six existing Leagues met together for the first national conference. Gradually one sees a realization come over these Leagues that simply "doing for others" is not enough, they must form a partnership with the professional workers, use their brains, not only their time and energy. Consequently, in 1921, we find the first training course for provisional members established. To get away from the so-called "bell-hop" work for other agencies the Leagues were urged by their leaders to operate their own projects. There followed the era of large enterprises such as convalescent homes, day nurseries, curative work shops and the like. As we might expect, it was soon discovered that a disproportionate amount of time and energy was going into money raising to the exclusion of the educational process of volunteer service. In order to counteract this mistake and to make more time for actual service, the Leagues are now being urged not to run these big projects alone, but to make them representative of a community-wide effort.

Nineteen twenty-one saw the formation of the Association of the Junior Leagues of America, Inc., which now comprises one hundred and ten Leagues in the United States, three in Canada, and one in Mexico City. Believing that anything which enhances the enrichment of living can be legitimately called social welfare, effort is going into the production of children's plays, "Arts and Interests" programs,

support of civic orchestras and the like, but every League engages in some kind of philanthropic work.

DEVELOPMENT OF VOLUNTEERS

What are the next steps? It does not take a great amount of speculating to answer:

A more professional attitude on the part of the volunteer toward her work, achieved by more leadership on the part of the professional groups.

Active participation on the part of the Association in raising local standards.

Proper placement of the individual volunteer rather than group placement is the point which both the Junior Leagues and all the social agencies must consider. The Junior Leagues are being urged by national headquarters to have one person in each League centralize the placing of volunteers and if each of the agencies with which they coöperate could also have a central person in charge of volunteers, an efficient system would be evolved. Interpretation is an important function of volunteers, not only to tell the community what the organization does, but to explain to the public what preventive health work is and how all are served by it.

Sixty-eight Leagues last year coöperated with local public health or visiting nurse services, either by giving volunteer service or contributing financially. Motor corps and clinic aid work are the two types of service most frequently performed. The approach to the job varies with different local associations, but all too often an opportunity of making the volunteer see the effectiveness of her contribution is missed. She should be impressed with the fact that she is complementing the work of the staff, not supplementing. When the young nurse first goes on the staff, she may not have experience, but she has a background of training and education in public health. The young volunteer has neither experience nor knowledge, so the supervisor must take the time to give her a picture of the whole in order that she may see how her contribution is a cog in a wheel. Sometimes it is difficult to take time to paint the picture of the whole wheel, but how vitally important! For instance, acting as a nurse's chauffeur may be helpful to the nurse, but if the volunteer's affiliation with the organization stops there, will she develop into an intelligent and well-informed board member? Certainly she will not, as her job will bore her, offer no incentive to work up to a more responsible and more interesting position, nor stimulate her to read or study. On the other hand there are many types of work in a visiting nurse service which do give the volunteer a sense of accomplishment and of participating in a definite plan to bring a patient back to health. Certainly we all can make a distinction between the trained volunteer and the beginner and adjust the duties accordingly. In other words, a willingness on the part of the supervisor to give more responsibility to the volunteer who has been trained and who has proved her trustworthiness is necessary to hold these mature volunteers who of course will be the best material in the group.

SUGGESTIONS FOR VOLUNTEER SERVICE

Volunteers like titles and a clever supervisor will recognize this and make a distinction between the various types of jobs and degrees of responsibility entailed. A fault found frequently among professional people is that they start on the assumption that the volunteer will be late and sometimes not turn up at all; at the same time they are grateful to her for assisting with some of the simpler tasks and do not wish to estrange her. This puts the relationship between volunteer and professional member on a false basis from the beginning.

The initial conference between the supervisor and volunteer is all-important. The League should understand that not every girl will be acceptable, and that the nursing director or chairman of volunteers wishes to interview her as if she were an applicant for a job, which she is. Ask her to fill out a formal application blank and give

references. On this blank her hours should be clearly stated and the type of work. Then assume that she will be reliable and let her know you are expecting definite things of her. If she fails too often, let her go. The psychological effect of such a step will raise the whole standard of volunteer service throughout the League.

On the other hand a sympathetic understanding of the needs of the volunteer must be a guiding principle. Too often a mature volunteer is frightened by the technical efficiency of a young staff. Volunteers do not want gratitude, they want to share with the professional staff in the satisfactions of the job. They are working toward the same goal as the type of staff member to whom a pay check is a secondary matter.

Again, let me emphasize, the Junior League is a challenge to the professional group. Its faults will always be those common to youth, but if a sympathetic understanding on the part of trained mature people is forthcoming, these twenty-two thousand young women should develop not only a social-mindedness but a really active interest in welfare work. Without such guidance the aims of the Association of the Junior Leagues of America can never be realized.

The New Volunteer

By ELLEN WINDOM WARREN GEER
Executive Secretary, Association of Volunteers in Social Service, New York City

DURING the last decade a new movement has gradually been gaining momentum. After the high grade volunteer service of the war years, came the inevitable swing of the pendulum toward careless, sloppy, volunteer work. Seeing the danger of losing that essential partnership between informed laymen and expert professional workers, both groups in recent years have devoted considerable thought and effort to improving standards of volunteer service. With this winter comes the great opportunity to evaluate just how much headway this "better volunteer" movement has made. Although lacking the drama of war time, the present unemployment situation offers many of the same difficulties which confronted us in 1917. Unusual pressure of an emergent nature brings a need for volunteers to carry the extra burdens of overworked staffs when budgets do not permit sufficient expansion to cope with unusual conditions.* We have then, this year and probably next, a unique opportunity to prove whether the qualitative methods of placement, training, and supervision, which many groups such as the Junior League, Councils of Social Agencies, and the Association of Volunteers in Social Service have been evolving, will stand up under the severe test of quantitative use to which they are now being subjected.

In the office of the Association of Volunteers in New York City are now two full time paid workers doing what was started six years ago by a few volunteers who desired to improve their own services. During the last two months over one hundred and fifty women, and some men have been placed in established agencies where they can be of most value. Four training courses are being offered by this organization to equip volunteers to do their work in as efficient a manner as possible. The success of these efforts has been so outstanding in the permanence and satisfaction of the placements and in the increased value of the volunteers' service that a short description of the methods used may

* Except in times of epidemic when the supply of nurses fails, volunteers should not be used to take the place of workers the association can afford to pay. Volunteer service is understood as being complementary to the administration of the nursing service.—*Editorial Note*.

be desirable should other communities wish to organize a similar service.

Each volunteer who applies for work is given a personal interview of at least half an hour in length. During this conference an effort is made to ascertain the previous experience, talents, hobbies, interests and preferences of the candidate. References are asked for and always cheerfully given. While the applicant is in the office the placement secretary looks over the available openings, discusses with the volunteer the ones which seem most suitable on the basis of the information furnished, and then (a detail, but important) arranges an appointment for the candidate with the agency decided upon as the most appropriate. After the volunteer leaves the office all material on her abilities is sent to the agency which is going to interview her so that it will be well prepared to have an informed, intelligent talk when the candidate appears. A few days after the date of this appointment a follow-up telephone call is made to both volunteer and agency to discover whether the placement was wise. If there is any difficulty, another interview is held with the volunteer and if there seems sufficient cause a new placement with a different agency is made. Or, if the difficulty proves merely a misunderstanding, it is ironed out before it grows into something more serious, without the necessity of making a change.

So much for the simple yet effective means of placement. Its chief value lies in the recognition of the volunteer's right to individual advice and handling, and in the breadth and variety of opportunities available at any centralized placement office. So often the "unfit" volunteer is really a "misfit," and often misfit because the particular agency to which she applied had no opening which suited her tastes and talents. By having a clearing house where many agencies doing different sorts of work can turn, it is exceptional not to be able to find a really suitable opening for every candidate—if that candidate can at the same time be considered an individual and studied to find out what he or she can do best.

But with the placement, only half the job is done. From then on the success of the arrangement depends upon the volunteer, first, and the agency, second. Consequently, it has often been found necessary to do some changing of public opinion. The volunteer must be made to feel that she is just as responsible for her slighter share in the work of the agency as is the staff worker for her larger share. Irregular hours, careless work, unfulfilled promises are just as inexcusable from one who is working voluntarily as from one who is receiving a salary. This change of attitude on the part of the volunteer has been effected to a great extent by emphasizing these facts in the placement interview, by training courses which make the work so interesting it would be hard to neglect it, and by articles and bulletins for volunteers.

The attitude of the agency, however, is fully as important. Here are people who are willing to give up three hours, or three days, every week, as the case may be, to helping an agency. Shall we consider them merely a cheap convenience and unload upon them tasks which are left undone because they are so stupid that the staff workers dislike to tackle them? Or shall we study the volunteer and say: What can this individual give to our agency which will prove of maximum value; how can we help her to see how the particular job we give her ties up to our whole program and how that program integrates with the rest of social work? Are we remembering that far more important than the actual contribution of our volunteers is the potential power of their interpretation of public health nursing to the outside world and their training as informed, forward-looking board members?

Upon the answer to questions such as these depends the success of an agency in its handling of volunteers. Unless an association is willing to consider its volunteers sufficiently important to study them individually, plan

their work so it will steadily increase in interest and responsibility, and give them enough supervision to enable them to see what lies behind their particular job, then it is better, in my opinion, for that agency not to attempt to use volunteer service. Let us all, volunteers, staffs, and above all board members, find in the cloud of the unemployment situation some silver lining in this great chance to build up a modern volunteer service which will grow steadily to meet the changing demands of the next decade.

The County Nurse and Industry

The purpose and value of safety measures have long been realized by leaders of modern industry. The ideas and aims involved have also found expression in various governmental activities, such as the laws and regulations governing industry in the State of Oregon, operating under supervision of the State Industrial Accident Commission. One requirement under the Oregon law is organization and maintenance of active safety committees on industrial operations.

In order to develop the most efficient possible working unit as a nucleus for our safety activities, we undertook to establish classes composed of a selected number of employees, to be given a course of instruction in safety methods and measures and first aid practices as advocated by recognized authorities. The standard Red Cross course and textbook were selected, outlining a series of not more than fifteen lessons.

Excepting occasional postponements, these classes have met once a week for study and demonstration. Our instructor in first aid has been the County Nurse, who kindly volunteered to supervise this feature of the classes.

Attendance and interest shown have been fully up to expectations. Individuals taking serious interest in the study have been greatly benefited. The knowledge added to the general understanding of the group as a whole is an element of inestimable value, a fact open to actual demonstration in case of emergencies. Already there have been instances when members of these classes, because of instruction received, have been able to assist injured and prevent grave mistakes in dealing with cases of injured away from their occupations. Thus we have realized a new development in social service in the community as a result of this organized effort.

As already indicated, we are looking to the graduates of these classes to become the central force in our efforts to make and maintain our operations as safe as possible to our employees and to minimize as much as possible the effects of injuries when unavoidable accidents occur. We are entirely convinced as to the wisdom and value of the undertaking. The instructed men become more valuable employees, and because of this voluntary schooling on their part, both management and all other employees are benefited.

A word of special recognition and commendation in this case is due to our County Nurse, Miss Mai[illegible] Wetzel, who unstintedly and even enthusiastically is giving of her own time each study evening in order to assist our classes and men, without any provision whatever for any extra monetary reward. This willingness to be of service on her part serves to instil into the situation that other element of human interest without which all efforts at welfare become soulless and sterile indeed.

—J. E. Hellenius—Supervisor of Employees' Welfare, Weyerhaeuser Timber Co., Klamath Falls Branch, Klamath Falls, Oregon.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

AHEAD OF THE GAME WITH THE T.A.T. NEEDLE

Even when plenty of help is at hand, keeping a busy immunization clinic running smoothly with patients pleased, doctor proceeding at the tempo he likes best, and technique perfect, is not simple. Louise Sheddan, public health nurse at Keyser, West Virginia, sends some appropriate and interesting suggestions on immunization clinic technique for rural communities. Since questions of technique are sometimes debatable, we are also printing comments on this technique from Dr. Edward S. Godfrey, Jr., Director, Division of Communicable Diseases, New York State Department of Health:

In working in various places under various health officers, I have found that in each locality the technique used in immunization clinics has been different. The method which impresses me as being the cleanest and most efficient for a large number of subjects in a rural community is the one given below:

Four pyrex custard cups are used as containers, and six or eight 2 c.c. syringes and a generous supply of the best grade hypodermic needles are needed. The first two custard cups are used in preparing the arm. I usually have two lay assistants for this work. One washes the area thoroughly with alcohol 70 per cent and then paints a small area with mercurochrome 2 per cent, using a toothpick swab for this purpose. The second assistant dries the arm with cotton after the doctor has injected the serum. The other two custard cups are used by the doctor and nurse for the syringes. A piece of sterile cotton is put on the bottom of the cup to protect the points of the needles and the cups are then filled almost to the top with the alcohol solution. The nurse fills syringes and places the full ones in one cup while the doctor places the empty ones in the second cup. They are thus soaked in alcohol before use in another arm. In this way there is always a patient ready for the doctor and a full syringe for him to use. His time is thus conserved to the utmost—a very important item in rural communities.

To verify this technique I have had a technician make cultures to see if the alcohol is sufficient to take care of the contamination between cases. His reports from cultures were negative in every case.

It must be remembered that it is practically impossible to reboil needles when one is holding a clinic in a country school house unless one is fortunate enough to have one of the more expensive outfits. Furthermore we do not believe it is necessary. Before leaving for the clinic the custard cups, syringes and needles are boiled in an enamel stew pan with a cover and they are carried to the clinic in this sterile container. Carrying around such a pan may seem rather awkward, but so far we have found it a very good way—and a rural nurse is accustomed to bearing strange articles!

This method enables the clinics to proceed rapidly. Lay assistants take the names of patients as they come in and feed them to the clinic room in a continuous line. I find girl scouts excellent help in these clinics and always willing and anxious to be of service. Private duty nurses in this community who are not on duty have been most generous with their time and say they really get a "kick" out of helping us. The student nurses at the local hospital have been used and are very fine help. In large clinics I have used them to fill syringes and kept more than one room going in this way.

Dr. Godfrey's comments, indorsing the above procedure and making additional suggestions, are as follows:

The only doubt I have as to the efficacy of this method is in the practice of soaking the syringes in the cup full of alcohol. I would be somewhat fearful that a sufficient amount of alcohol might get into the syringes to effect a perhaps undesirable change in the toxin-antitoxin. I am not at all sure what this effect would be. It might be simply to change any free toxin to toxoid and not reduce the immunizing power of the mixture. Aside from this I can see no objection.

Our own experience has been that the few instances of infection following the administration of toxin-antitoxin have occurred with boiled needles. One of these was quite certainly due to infected toxin-antitoxin mixture—the other probably due to infected needles, or possibly to the syringe having been picked up by the extended piston.

The thought has occurred to me in this connection, that where sterilization by boiling was practiced for needles as they were used, there might be occasional contamination from touching the shaft of the needle when the butt of the needle was too hot to hold.

A great many of our own workers use the technique employed by Zingher, of simply wiping the needle on a pledget of cotton saturated with alcohol after each injection. No infections so far as I know have ever resulted from this method. It has the objection, however, of occasionally going contrary to the prejudice of visiting mothers.

An ingenious contrivance which can be made very cheaply was invented by Dr. Hervey of our department a few years ago and was described in our Health News for February 27, 1928.

(See also THE PUBLIC HEALTH NURSE, August, 1928.)

DOES YOUR KNOWLEDGE OF SOCIAL HYGIENE INCLUDE THIS?

The Syphilitic Clinic of the Hospital of the University of Pennsylvania, Philadelphia, gives the following material in mimeographed form to each of its patients. This has been prepared by the clinic and by the Department of Dermatology and Syphililogy of the School of Medicine of the University. The careful and understanding wording will help all of us to crystallize our own information and will aid us in the difficult task of interesting patients to carry out treatment ordered for them:

The examination and tests which we have made show the presence of a serious disease in your blood. This is syphilis. The germs of this disease get into your blood and are carried all through your system.

If not treated at once and thoroughly it may bring on many misfortunes. The danger of blindness, insanity, heart disease, stomach trouble and many other things may be avoided by being treated for this disease. Time is of great importance in the treatment of syphilis and the person who begins his treatment earliest and follows it with the fewest breaks and lapses is the one who is surest to recover. Apply this statement to yourself and pass it on to anyone you know who may be in the same condition. To come for treatment within the first week or two of a syphilitic infection makes as much as 35 per cent difference in the chance of getting permanently well, as compared with a person who does not come for treatment until he is all broken out and poisoned all through by the disease.

Some people have this disease and do not discover it until long after they first caught it. We cannot cure such a dangerous disease or such a long-standing trouble in a *short time*. If it has worked in the blood for many months we have to fight it an equally long time. Very often it takes as long as a year and sometimes longer to control a stubborn case.

We can put only a little of the powerful medicine in your blood at one time. So each week we accomplish as much as possible. If you stay away from clinic for several weeks, you then must make up this time. Your absence from clinic is very dangerous to yourself, for you run the chance of the germs getting the upper hand once more. Curing this disease is just like putting out a fire—if you leave some of the sparks, they may start the fire again.

Almost any person will eat something which upsets his stomach. He does not let this keep him from eating other meals. If our medicine should annoy you, you must not let this keep you from clinic. We can do nothing for you by "absent treatment." Come in and discuss the matter with the doctor on the following week. Sometimes it takes a little time for your system to get used to the medicine.

Before treatment eat lightly (no meat or rich foods). Be sure that your bowels have moved the morning of treatment day. After an *arm* treatment go home and lie down if possible. Omit your evening meal or eat very lightly (no meat, vegetables, desserts, or heavy foods). If your stomach feels upset, take chipped ice and rest quietly.

After a *hip* treatment always take a hot bath, sitting in the tub waist deep. The hip may be gently rubbed. Remain in the tub for twenty minutes.

Very soon after you start taking treatments the symptoms which brought you to us may disappear. You may also feel wonderfully improved. As well as acting on syphilis germs, our medicine acts as a tonic. Improvement does *not* mean cure.

As we treat you we take repeated tests of your blood to see how it is affected by the medicine. When the tests are negative you will feel encouraged, for it means that the medicine is taking hold. One negative test does *not* mean "cured."

Sometimes this disease gets into the spinal cord within a short time. (If this has happened, we give you a very special kind of medicine.) The only way we can tell if this has happened is by the "back test." For your safety we often ask to make this test immediately. Without this test you are running great chances. Syphilis in the brain, which may result from an infection in the spinal cord, can cause paralysis and insanity.

As the doctor has told you, syphilis is contracted through sexual relations, sometimes by kissing, and in other ways. The disease is very infectious in its early stages. Often people do not know they have it and therefore are very careless. If they could only know, they would make every sacrifice to be treated and to avoid spreading this trouble.

If you know from whom you caught this disease, or of some person to whom you may have unintentionally given it, it will be a great kindness for you to go to that person and urge him or her to come to us. It is a pity to let other people run the chance of great suffering, merely because they have not discovered the presence of the disease in their own systems.

We want you to be very particular in your habits if your condition is infectious. You should have your own dishes and see that they are scalded after using. Your laundry should be done separately. Never exchange or borrow shaving tools or toilet articles or other personal belongings.

After using bathtub or washbowl scrub thoroughly with soap and hot water. Sleep alone. Avoid alcohol and the use of tobacco. Get the doctor's instructions relative to sexual matters and follow them. Take plenty of exercise and sleep long hours. Tell the doctor of any colds, coughs, or sore throats which you have. Do not fail to appear in clinic regularly for your treatments.

This is a disease which can be transmitted from parents to their children and we want you to consider this very carefully. If you suffered from syphilis before your children were born, it will be wise to have them examined. Syphilis in children is a sad condition, and you will not want to stand in the way of your child's perfect health. Before you plan for any more children, you should consult your physician in this clinic.

We are acquainted with the addresses of hospitals all over the country treating this disease. If you expect to leave the city, let us direct you to the most convenient clinic in your new location. We can introduce you to the new clinic and make it possible for your treatment to continue.

We urge our patients to bring their problems and complaints before us. We feel that we can do much to relieve their fears and hasten the improvement of their condition.

Treatment for this disease is within the means of every person.

SPRING CLEANING FOR SAFETY

The Kitchen

Are the gas burners clean inside as well as outside?
Are matches in a safe place?
Is there an adequate rack for sharp knives?
Have inflammable lamp shades been removed?
Is the clothes rack at a safe distance from the stove?

The Stairs

Are they absolutely free of anything that will trip a person?
Are they adequately lighted?
Have they strong hand rails?

The Cellar

Is it adequately lighted?
Has all accumulated rubbish been removed?
Is the furnace clean?
Are there metal containers for ashes?
Has kindling been piled neatly at a distance from the furnace?
Is insulation on electrical extensions to the washing machine in good shape?
Are the laundry and gas stove burners clean inside as well as outside?

The Living Rooms

Are small rugs on polished floors anchored down?
Are floors too highly polished?
Are electric extensions to radios, floor lamps, etc., over-burdening the circuits?
Have small rugs (which slip easily) been removed from the head and foot of stairs?

The Bath Room

Is the water heater thoroughly safe?
Is the vent pipe doing its job?
Is there a strong brace to hold on to when you get in or out of the tub?
Are bottles of poison in the medicine chest plainly marked with pins in the corks?
Are these poisons inaccessible to children?
Is there a safe place for used razor blades?

The Attic

Has all accumulated rubbish been removed?
Have castoff clothes, worn-out bedding, etc., been disposed of?
Are magazines and books piled neatly and at a distance from other inflammable material?
Are the attic stairs lighted and free from obstructions?

The Nurse's Car

Is it adequately insured?
Is it provided with chains, working brakes, tested lights?
Are the upholstery, floors and windows clean?
Has it automatic windshield wiper?

The Nurse's Bag

We leave this to the imagination of our readers!

REVIEWS AND BOOK NOTES

Edited by RUTH GILBERT

RURAL INTERESTS AND PROBLEMS

This is the time of year when country roads—the "mud roads"—are impassable, and when farm work is at a standstill. The farmer repairs machinery and patches his harness in preparation for the spring work. The rural nurse, too, with much of her territory under a blanket of snow or mud, can spend some time in refreshing her information and setting her own mental machinery in order before her spring field work also starts. It is hoped that the following suggestions for reading will be useful to the rural nurse. And since statistics show that 48 per cent of the population of the United States is on the farm, rural situations hold interest for all of us.

RECENT RURAL BOOKS AND PAMPHLETS

INTRODUCTION TO RURAL SOCIOLOGY

By Charles Russell Hoffer, Ph.D., Associate Professor of Sociology, Michigan State College. Published by Richard R. Smith, Inc., New York. 1930. $2.50.

Mr. Hoffer has written a remarkable book which might well be in the hands of every nurse, social worker and board member interested in rural conditions. He limits his discussion to those facts which he states characterize rural life in all parts of the country.

In a chapter on the health of the rural population he has presented a great variety of material on health in the country and facilities for meeting the problem. Hoffer believes that rural communities could provide themselves with physicians through some form of health insurance by which a doctor would be assured a dependable income and the expense be distributed more evenly among the families in a given area.

In a very well written chapter on Dependent and Delinquent Classes, the various problems of social maladjustments are discussed. Social Case Work is described and the need for "undifferentiated social work" with the community as a unit supported by public funds, is emphasized.

After discussing the rural population and its characteristics, Dr. Hoffer has a section on Rural Institutions and another on Rural Social Organizations. In the latter is a chapter on the international aspects of Rural Social Organizations which will help the professional worker with country people to see rural life in world wide significance. His last chapter on the Study of Rural Life has a number of suggestions of further investigations which need to be carried on.

Not the least valuable part of this interesting book is the carefully selected and short bibliography at the end of each chapter.

WALTER W. PETTIT

FARM CHILDREN

By Bird T. Baldwin, Eva Abigail Fillmore, and Lora Hadley. D. Appleton & Company, New York. $4.00.

Surveying a map of her district, the rural public health nurse may question why certain areas might be labeled with golden letters, as a measure of her progress and success, while others must be painted in heavy black type, regardless of an equal amount of time and effort spent in each community.

"Farm Children," the report of an investigation of rural child life which was carried on in selected areas of Iowa for a period of five years, gives an interpretation of community differences based on a most thorough and detailed study. The primary object of the research was a "beginning towards

a better understanding of children in rural homes and communities; to interpret certain phases of child life, and the distinguishing factors affecting it in various rural localities." This object has been consistently maintained.

There are chapters, such as one on "Educational Achievement," which are of more interest to the educator than the nurse. However, those on "Farm Advantages and Disadvantages," "The Mother and the Preschool Child" and others, are written with particular insight into the difficulties that confront a rural public health worker.

Appendix I, on the collection of data, gives helpful information to anyone interested in a rural problem, regardless of type. Those who have discovered by trial and error, the facts brought out in this portion, can appreciate it as a most valuable help.

It is interesting to note that the suggestions of problems for future study, which grew out of the investigation, are concerned, in large proportion, with mental and physical health.

RUTH G. TAYLOR

THE COUNTRY CHURCH AND PUBLIC AFFAIRS. Edited by Henry W. McLaughlin. Macmillan, New York. $2.00.

The twenty chapters in this volume, by almost as many authors, are the outgrowth of the Open Forum and Round Table studies, and discussion on "The Task of the Country Church" in the 1929 Institute of Public Affairs at the University of Virginia.

PROGRAM FOR ELEMENTARY SCHOOL LIBRARY SERVICE. By Lucile F. Fargo. American Library Association, Chicago, Ill. $2.25.

Miss Fargo analyzes four typical situations and formulates programs to meet the needs and resources of each: An isolated village of 2,500 inhabitants; a city of 150,000 inhabitants; a rural county with a few consolidated schools and a number of isolated districts; and a prosperous city of 300,000 inhabitants. The situations vary as much in the attitude of the population as they do in size, locality, and available funds.

To summarize the typical problems arising in these various localities, a chart is drawn up which makes possible the analysis of any local situation, and suggests plans of procedure in setting up a library program. This chart, as well as Miss Fargo's discussion throughout the volume, is remarkable for its flexibility.

The author, who was recently appointed by United States Commissioner of Education Cooper on a committee to make a national survey of secondary education, is now directing the training of school librarians at the George Peabody College for Teachers.

HOME-MADE PLAY APPARATUS FOR THE RURAL PLAYGROUND. By John F. Smith, Berea, Kentucky.

This pamphlet is reprinted from "The Playground." It gives directions for making simple play apparatus appropriate to rural schools or playgrounds. Obtainable from the Secretary, Berea College.

PHYSICAL CARE OF RURAL SCHOOL CHILDREN. By Taliaferro Clark, M.D. United States Public Health Service, Washington, D. C.

RURAL COMMUNITY LIFE. By Lee Ora Lantis. American Book Company, New York, Chicago, 1930. $1.40.

This book discusses, through four approaches, social conditions in rural communities, and offers suggestions for improving the standard of living of rural citizens.

TEACHING HEALTH IN RURAL SCHOOLS. American Child Health Association, 370 Seventh Avenue, New York City. 5c.

RURAL SCHOOL NURSING. American Red Cross, Washington, D. C. 78 pp. 25c.

STANDARDS OF LIVING. University of Wisconsin, College of Agriculture, Madison, Wisconsin. Extension circular, 241. 1930. 79 pp. Prepared for use as a source book for the 1930 National Country Life Conference, and published in coöperation with the American Country Life Association.

The material is divided into three sections, the first defining terms and discussing evolution of standards and former studies as measures of the standard of living. The second section summarizes the most available data on standards of living in rural families. The third section suggests some seven

factors involved in the improvement of standards of living.

THE PLACE OF AGRICULTURE IN AMERICAN LIFE. By Wilson Gee. The World Today Bookshelf, under the editorial chairmanship of Charles A. Beard. Macmillan, 1930. $2.00.

A thoughtful presentation of the social, economic, political and agricultural status of the farmer today. Health is very briefly touched upon.

RURAL SCHOOL HOUSES. School Grounds and Their Equipment. Office of Education, Washington, D. C. 10 cents.

The following books dealing with rural subjects have been reviewed in recent numbers of THE PUBLIC HEALTH NURSE: Children at the Crossroads, by Agnes E. Benedict (22:599, November, 1930); A Chapter of Child Health, and Children of the Covered Wagon, the latter by Estella Ford Warner, M.D., and Geddes Smith, Commonwealth publications (22:600, November, 1930).

ABOUT RURAL PROBLEMS

(Articles published in 1930)

Amos Putnam, Match-Maker. Lois Patterson. Bureau Farmer (Texas Farm Bureau Federated News), 6:16–19, September, 1930.

One of the twelve prize-winning plays in the contest conducted by the home and community department of the American Farm Bureau Federation.

China, A rural health experiment in. Quarterly Bulletin, Milbank Memorial Fund, New York City, p. 97, October, 1930.

A five-year public health demonstration is now under way in Ting Hsien, one of the northern counties of China, under the auspices of the Chinese National Association of the Mass Education Movement. With the help of a financial grant from the Milbank Fund, they are putting on a program of public health, agricultural extension, industrial education, social surveys, and research in methods of teaching. Public health activities are very new in China, and the rural part of the country is a virgin field for the application of the principles of modern medicine and sanitation. Over 90 per cent of the people of the county chosen for the demonstration are illiterate, and most of them are poor and superstitious, living in smoke-blackened and vermin-infested mud huts. In the entire county of 400,000 population there is not a single qualified trained physician. This article gives some details as to the condition of the county and the plans adopted for the demonstration.

Coöperative rural health work of the Public Health Service in the fiscal year. United States Public Health Reports, 45:2613–33, October 24, 1930.

County Superintendent. J. T. Anderson. Journal of the National Education Association, 20:9–10, January, 1931.

The county superintendent is the key to the problems of rural education. Where he is able, well trained, well paid, secure in tenure and a real leader of the people of his county, reforms needed in rural education quickly come about.

Education of handicapped children in rural schools. School Life, 16:9, September, 1930.

Evaluating certain equipment of the modern rural home. Carroll D. Clark, Storrs Experimental Station, Storrs, Conn. Journal of Home Economics, December, 1930.

Extent of rural health service in the United States, 1926–30. United States Public Health Reports, 45:1065–81, May 9, 1930.

Guidance problems in rural and village communities, Child. Sanger Brown II, The Annals of the American Academy of Political and Social Science (Philadelphia, Pa.), 149:175–79, May, 1930.

Describes conditions in New York State.

Guidance in rural schools. Prepared by the National Vocational Guidance Association Committee on Guidance in Rural Schools. Vocational Guidance Magazine (Cambridge, Mass.), p. 3, October, 1930.

The committee presents a syllabus suggesting a working basis for developing guidance programs in rural schools and describing the methods adopted for such programs in various states. Pennsylvania has been the pioneer in this type of work, and 83 counties of the state have undertaken rural-guidance programs.

Health of the farm woman. Caroline Hedger, Farmer's wife (St. Paul, Minn.), 33:20–21, December, 1930.

Hospital, The rural—An essential link in medical program. H. J. Southmayd, Modern Hospital, 35:61–66, December, 1930.

The Commonwealth Fund has recently helped to build six rural hospitals, which are now in operation under local administration. Mr. Southmayd, the director of the division of rural hospitals of the Commonwealth Fund, tells how these institutions were planned, their place in the community, and the part they are playing in developing a better foundation for rural medicine.

Hospitals as health centers, Rural. M. K. Nelson. PUBLIC HEALTH NURSE, 22:86–87, February, 1930.

Medical situation, Rural. Carroll P. Streeter. Rural America, 8:9–10, January, 1930.

Medicine and public health, Rural. J. G. Stone. Journal of Outdoor Life, 27:33–34, January, 1930.

Nursing in Hungary, Rural. A. M. Wacker. PUBLIC HEALTH NURSE, 22: 191–93, April, 1930.

Nursing, Rural public health. J. L. Marriner. American Journal of Nursing, 31:45–52, January and February, 1931.

A vocational study of interest to student nurses.

Plays for farm meetings. Edna La Moore Walch. Farmer's Wife, 33:24, 61, October, 1930.

Names and describes some plays suited to farm meetings. A list of the plays and information on where to get them is given at the end of the article.

Rural life and the rural school. Joy Elmer Morgan. Journal of the National Education Association, 20:10, January, 1931.

A plea for a United States college as a special training agency for county supervision and rural school supervision.

Social hygiene problems, How Alabama meets her. D. G. Hill, M.D. Paper presented at the Southern States Conference of the American Social Hygiene Association, New Orleans, May, 1930. Journal of Social Hygiene, 16:530–32, December, 1930.

A scheme of coöperative clinics throughout a rural state. The 175 clinicians are practising physicians who have been appointed by their own county medical societies, subject to approval by the State Board of Health.

Solution of rural health service in Massachusetts. G. H. Bigelow and W. W. Knowlton. New England Journal of Medicine, 203:477–78, September, 1930.

Standards of living, Rural. Frank O. Lowden. Rural America, 8:8–11, November, 1930.

Trail blazing in social work. K. D. Hardwick. PUBLIC HEALTH NURSE, 22:115–21, March, 1930.

Trends and problems in rural social work. Dwight Sanderson. Rural America, 8:3–6, January, 1930. Also PUBLIC HEALTH NURSE, 22:59–64, February, 1930.

What rural life offers women today. Gus W. Dyer. Southern Agriculturist (Nashville, Tenn.), 50:4, 11, June 1, 1930.

"The leadership in saving the American home and thereby saving American civilization is now offered to those living in the country, and especially the country women and country girls."

Why there is a shortage of country doctors. N. P. Colwell. Hygeia, 8: 640–43, July, 1930.

Some recent books on Tuberculosis include:

"Childhood Type of Tuberculosis Diagnostic Aids." Henry D. Chadwick and F. Maurice McPhedran. Published by the National Tuberculosis Association, 1930.

"Tuberculosis in Public School Children." A study from the Henry Phipps Institute of the University of Pennsylvania. Reprinted from the American Review of Tuberculosis, October, 1929.

"Health in High Schools." Four articles published in a second edition by the National Tuberculosis Association, October, 1930.

"Tuberculosis Among Children." By J. Arthur Myers. Charles C. Thomas, publisher, Springfield, Ill. 1930. $3.50. The childhood type and the adult type of pulmonary tuberculosis are described as well as non-pulmonary tuberculosis in children.

The publication, beginning this month, of a quarterly magazine, *The Sight-Saving Review*, devoted to all aspects of prevention of blindness and conservation of vision, has been announced by the National Society for the Prevention of Blindness. The new journal is designed to meet the needs of state and local prevention of blindness workers, educators, illuminating engineers, school physicians and nurses, safety engineers, public health administrators, industrial physicians and nurses, sight-saving class teachers and supervisors, ophthalmologists, and any one interested in the sociologic phases of saving sight. For information write to the Society, 370 Seventh Avenue, New York City.

NEWS NOTES

The Department of Biology and Public Health of the Massachusetts Institute of Technology in Cambridge announces a scholarship for public health nurses in Health Education to be awarded the next academic year. The scholarship will carry full tuition and is open to those wishing to prepare themselves for professional work in health education. The scholarship is to be awarded before the last day of July, 1931, upon the basis of previous academic record, professional accomplishment in the field of health education, need and likelihood of future contribution to health education. This is the second time this scholarship has been offered to public health nurses.

Those wishing to apply for this scholarship should send at once for application blanks to the General Director of the National Organization for Public Health Nursing, 370 Seventh Avenue, New York City. Applications close May 15, 1931. Candidates must be high school graduates. Special perference will be given to those who have had some college training in sciences, such as biology, physiology and bacteriology.

A regional conference of New Jersey Child Hygiene Nurses was held at the Academy of Medicine in Newark on January 24. Three hundred nurses and visitors were addressed by Dr. Julius Levy, Consultant of the Bureau of Child Hygiene of the State Department of Health, and Ruth Gilbert, R.N., Assistant Director of the National Organization for Public Health Nursing. Alice Boyer, R.N., Supervisor of Nurses in the Bureau of Child Hygiene, was chairman of the meeting and introduced the speakers.

These conferences arranged by the Child Hygiene Bureau are held at intervals in different parts of the state—for the purpose of helping solve problems in child care and bring to the nurses the most recent developments in this field. According to the State Department of Health reports there are 146 nurses at work throughout the state engaged in carrying on New Jersey's Continuous Child Hygiene Program.

The twenty-fourth annual meeting of the American Home Economics Association will be held in Detroit, June 22–27. The general theme for the meeting will be the rôle of the home in individual and family development.

The American Public Health Association will hold its annual meeting in Montreal, Canada, in September, 1931.

The Fourth Annual Meeting of the American Association of School Physicians will be held in Montreal, Canada, September, 1931.

The fourteenth annual American Country Life Conference will be held at Cornell University, Ithaca, N. Y., August 17–20. Topic, "Rural Government." Further information may be had from the American Country Life Association, 105 East 22nd Street, New York City.

Fifty-two nations have been invited by President Hoover to participate in a World Conference on Work for the Blind in New York City, April 13–19. Twenty-seven countries have accepted.

The Northwestern Division of the American Nurses' Association will hold its biennial meeting June 11, 12, and 13 in Seattle, Washington. Elnora Thomson, president of the American Nurses' Association, and Janet Geister, executive secretary of the American Nurses' Association, will be leaders of the meeting.

The Commonwealth Fund has decided upon Mississippi as the third state in which to develop its rural health work. Like Tennessee and Massachusetts, where the program of the Fund is already under way, Mississippi was chosen as a state having a progressive health policy under a system that safeguards the professional character of public-health service. With the addition of this state the rural health project now faces the characteristic problems and psychology of the far South as well as of the border states and the North.

The plan of the National Congress of Parents and Teachers for its 1931 "summer round-up" of the preschool children will place emphasis on the following points: (1) The proportion of children entering school in the fall who have been examined by a physician and a dentist, and (2) the proportion of children whose parents followed the recommendations given when the examination was made in the spring. A second examination in the fall will not be required, but a check-up must be made to determine whether the advice with regard to medical and dental attention has been followed and how far corrections have been made. A folder giving suggestions about the organization of the campaign has been prepared for distribution to local units of the congress through the state chairmen.

With the approval of the British Medical Association, the doctors in the County of Essex have inaugurated a public medical service for the benefit of middle-class men and their families who are not covered by the National Health insurance scheme. The plan offers a full medical service at the rate of one penny a head a day. The actual subscription is thirty shillings a year, but, in families of more than two children, the third and every succeeding child will be admitted at £1 a year, and more favorable rates will be arranged for unusually large families.

The International Society for Crippled Children, Inc., will meet in Cleveland, O., April 12–15, headquarters: Statler Hotel. Programs may be secured from the Society at Elyria, O.

APPOINTMENTS

Blanche Elrod, as Washington County Public Health Nurse, Indiana.

Neva Pumphrey, as staff nurse of the Crippled Children's Commission, Michigan.

Marion K. De Young as school nurse, Grand Rapids, Mich.

Frances Buck will assist with the educational program of the Queensboro Tuberculosis Association, Jamaica, L. I., N. Y.

Nell Fay Stewart, tuberculosis supervisor, Visiting Nurse Association, Youngstown, Ohio.

Loretta Bigley, teacher of public health to students of Jersey City Hospital, Jersey City, N. J.

Hattie Hemschemeyer, secretary to the Committee for the Promotion and Standardization of Midwifery, Maternity Center Association, New York City.

Eleanor Kennedy, state supervising nurse, Bureau of Public Welfare, Santa Fe, N. M.

Emma Bergonan as school nurse, Robbinsdale, Minn.

Lynne Gilkey, as school nurse, St. Paul, Minn.

Monica Wieber as field nurse with the State Division of Child Hygiene, on White Earth Indian Reservation, Mahnomen, Minnesota.

Ila G. Henry, as epidemiological nurse, Bureau of Communicable Diseases, New York State Department of Health.

Mathilde Kuhlman, director of the Division of Public Health Nursing, New York State Department of Health, has been elected councillor of the Section on Public Health Nursing of the American Public Health Association.

For Joint Vocational Service Appointments see page 140